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Preventing Substance Use Problems Among Young People

A Compendium of Best Practices

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Preventing Substance Use Problems Among Young People

A Compendium of Best Practices

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Table of Contents

Section 1: Introduction 1

Scope of the Compendium Key Terms 1
Key Terms 2
Methodology 2
Exemplary Programs from the Scientific Literature 3
Exemplary Canadian Programs 4
Limitations 4

Section 2: Substance Use Patterns of Canadian Youth 6

Recent Trends in Use 6
Current Patterns of Use 8
General Prevalence 8
Age at First Use 10
Age Differences 10
Peak Use 11
Gender Differences 11
Heavy Use 12
Harmful Effects and Particular Risks Reported 13

Conclusion 14

References 15

Section 3: Principles of Youth Substance Use Problem Prevention 21

Build a Strong Framework 22
Address Protective Factors, Risk Factors and Resiliency 22
Seek Comprehensiveness 24
Ensure Sufficient Program Duration and Intensity 26
Strive for Accountability 29
Base Program on Accurate Information 29
Set Clear and Realistic Goals 30
Monitor and Evaluate the Program 32
Address Program Sustainability from the Beginning 33

Understand and Involve Young People 35
Account for the Implications of Adolescent Psychosocial Development 35
Recognize Youth Perceptions of Substance Use 37
Involve Youth in Program Design and Implementation 38
Create an Effective Process 39
Develop Credible Messages 39
Combine Knowledge and Skill Development 41
Use Interactive Group Process 43
Give Attention to Teacher or Leader Qualities and Training 43

Conclusion 44

References 45

Section 4: Exemplary Programs from the Scientific Literature 53

Special Focus: A Summary of Evaluations of the Drug Abuse Resistance Education (D.A.R.E.) Program 171

Section 5: Exemplary Canadian Programs 174

Section 6: Appendix 275

Prevention Principles Checklist 276
Study Quality and Outcomes Rating Form 280
Reviews of Youth Substance Use Problem Prevention Effectiveness 281
Articles Associated with Published Programs 282
Index of Published Programs 286
Index of Canadian Programs 287

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Section 1

Introduction

There has been a general increase in substance use and associated problems among adolescents in this country in recent years. Various government and non-government organizations are being pressed to respond with effective solutions. This compendium presents evidence-based direction to effective programming for a broad range of prevention activities and should be of interest to educators, community developers, health promoters, law enforcement officers and public health nurses.

Scope of the Compendium

- What is the best way to prevent substance use problems among young people?
- What about effective programs to reduce harm for youth already using substances?
- What Canadian programs show most promise?

The compendium gives attention to prevention issues, principles and programs pertaining to all youth, ranging from mainstream to out-of-the-mainstream, and considers a variety of settings, from schools to street level. While some early childhood initiatives have shown strong preventive effect, they were considered beyond the scope of the investigation. Also, neither tobacco nor performance-enhancing drug use prevention programs were considered unless they reported other substance use results. Finally, policy-focused initiatives were considered only when linked to programming, but were discussed as an important underpinning to the direct service programs presented in this compendium.

Detailed discussion of current drug use patterns of Canadian youth is presented because it is crucial to base program decisions on accurate data. A number of programs that have either shown evidence of effectiveness or show promise are described in detail. To the greatest extent possible, relevant information has been collected from researchers and program sponsors, including aims, intended outcomes, prevention principles emphasized and, whenever possible, cost information. Complete contact information is included for each program.

Each of the programs presented reflects a number of prevention principles; however, it is wise to determine the extent to which programs being considered reflect the principles that are of greatest importance to you, rather than simply adopting a program.

The discussion presented in each section is relatively detailed; however, for those interested in investigating issues further, significant points are supported by cited sources to allow for follow-up.

In the appendix, a checklist is provided to guide an analysis of programs in relation to prevention principles. Also included in the appendix are various tools and resources for those interested in pursuing further research.

Key Terms

Substance use problem prevention: This term is used because it accommodates prevention in two contexts: (a) prevention activities designed to encourage youth not to use, and (b) activities designed to encourage users to avoid high-risk practices that could lead to serious problems or harm.

Youth: For the purposes of this compendium, the population of interest is young people in their teen years. Because psychosocial development is often delayed among high-risk youth, programming for these young people up to approximately age 24 is considered. Prevention necessarily involves a time period prior to the period of interest; consequently, later childhood (ages 7-12) issues are also part of this investigation. Youth are not a homogeneous population. At various points, the compendium accounts for distinctions between sub-populations of youth based on gender, urban-rural differences, level of risk, cultural background and stage of psychosocial development.

Universal, selective and indicated prevention: In this compendium, these terms replace the terms, primary and secondary prevention (tertiary prevention refers to treatment). The model was first described by R. Gordon in 1987 and was adapted by the US Institute of Medicine Committee on the prevention of mental disorders in 1994. It was applied to substance use issues by the National Institute on Drug Abuse in a 1997 publication, "Preventing drug use among children and adolescents: a research-based guide". The terms are more fully discussed in the Prevention principles section.

Methodology

Substance Use Patterns of Canadian Youth

A key premise of this resource is that prevention activities need to be based on the best available information on the nature and extent of youth substance use problems. Section 2 of the compendium sets the context for later discussion on principles and programs by detailing the current patterns of youth drug use in Canada. The information presented is based on an analysis of the most recent government surveys as well as key journal articles on the epidemiology of youth substance use in Canada. This section will detail information on age of first use, age and gender differences, age of peak use and problems reported from use. The following section shows how this information can guide program development.

Principles of Youth Substance Use Problem Prevention

Section 3 presents 14 principles that represent a consensus of the project team and steering committee on the most important considerations in developing and implementing youth substance use problem prevention programming. The principles were arrived at through an extensive review of the literature and other consensus-based statements from authoritative bodies.

Exemplary Programs from the Scientific Literature

> Whether a programmer is developing a new program, revising an existing one, or considering the purchase of a marketed program, these principles provide sound direction.

This section describes and analyzes 33 programs with a range of aims, target groups and settings that have been shown to be effective through rigorous evaluation. Among the programs presented are eight that focus on the unique needs of injection drug using (IDU) youth. Programs in this section were identified through a process which:

- defined a minimum standard for inclusion into the candidate pool, which was a quasi-experimental design reporting positive effect on substance use measures in a peer reviewed journal;
- developed a matrix that categorized programs according to target group (universal, selective or indicated) and setting (school, family/parent, community, combined, street);
- reviewed nine credible reviews of effective programs and compiled a list of programs that met inclusion criteria;
- identified poorly represented areas of the matrix: high risk/street/IDU youth, DWI programs, parent/family programs;
- conducted a second, targeted search of the literature to fill in gaps and to capture any program evaluations reported in the scientific literature since the most recent reviews, (i.e., 1998 to 2000). Databases searched: CANBASE, CCSADOCS, CEI, ERIC, Medline, ETOH, NCADI and the French-language databases of the Centre québécois de documentation en toxicomanie, and the National Documentation Centre in Lyon, France;
- developed a coding form to rate each study on quality of research design and study outcomes;
- checked the reliability among three raters;
- rated 115 articles and selected 33 programs that ranked highest in overall quality of research design and outcomes;
- described the 33 programs based on information contained in research articles;

- sent description to principal authors of research articles for confirmation of information; in several cases, the request was forwarded to those marketing commercial versions of described programs;
- entered new information from authors or publishers.

Exemplary Canadian Programs

This section presents descriptions of 39 Canadian programs, including eight serving IDU youth. Among the programs serving IDU youth are treatment programs that are presented in this Compendium because they are engaged in the prevention of harmful effects associated with injection drug use. Programs in this section were identified through a process which:

- invited nominations from provincial/territorial government addiction agencies and Health Canada regional representatives;
- filled in gaps with nominations from key informants across Canada, programs known by team and steering committee members, and, in the case of IDU programs, an Internet search;
- developed a questionnaire/template that was sent to a total of 150 programs;
- conducted a first screen on the basis of a mix of considerations (i.e., availability of evaluation report, evidence of sustainability, degree of innovation, the extent to which prevention principles are reflected, and geographic and cultural representation);
- made personal contact with persons associated with youth treatment and general IDU programs to determine the extent to which they work with IDU youth;
- due to lack of available documentation, collected required information from screened-in IDU programs by interview; and
- developed descriptions of 39 programs based on information provided by questionnaire and interview, and forwarded to program sponsors asking for confirmation of information and elaboration in several areas;
- entered information into fully searchable database.

Limitations

Considerable effort went into conducting a broad investigation and adhering to a strict method; however, the following limitations were noted:

- when rating the published and Canadian programs, the author or sponsors interpretation of outcomes and other key information was used;
- while several approaches were used in the search for Canadian programs, it is quite possible that important programs were not nominated;
- because outcome evaluations are almost completely non-existent among Canadian programs, the criteria for selection of these programs became necessarily less stringent;

- program cost information is important in determining the efficiency of prevention activity. Effort was made to obtain direct cost information from authors and sponsors, however the information obtained is uneven and generally weak;
- due to their being marginalized, IDU youth are not as easily studied or served; as a result, the type of research or documentation made available didn't allow for the same level of confidence in outcomes as was generally the case;
- follow up contact was made with all "screened-in" candidates, however a small number of principal authors of published programs and sponsors of Canadian programs chose not to participate and were not included in the Compendium.

Section 2

Substance Use Patterns of Canadian Youth

Substance use patterns among young people are determined by many factors and are constantly evolving. It is important that programs base their activity as fully as possible on data describing current patterns of use. Age at first use, the proportion of users vs. non-users, gender and age differences, and the point of peak use all hold important implications for aims, timing and messages of interventions. This section reviews recent national and provincial studies of youth both in and out of school, as well as other key research, to develop a detailed profile of youth substance use in Canada. This information holds a number of important implications for program development that are detailed in the Prevention principles section that follows.

National and provincial student substance use surveys, together with studies of street youth and local epidemiological assessments of problems, provide good information on patterns of use, and offer a sound basis for program development decisions. A key reference for this investigation was a recent Health Canada review that analyzed and compared findings from surveys conducted in nine provinces between 1994 and 1996.[1] More recent student surveys, from Ontario (1999),[2] the Atlantic Provinces (1998),[3,4,5,6] British Columbia (1999)[7] and Manitoba (1997),[8] as well as Canada's contribution to the International Health Behaviours of School Age Children study (1999)[9] have been reviewed.

Student surveys give an indication of the substance use patterns of most youth in the 12-19-year-old range (i.e., Grades 7 to 12 or 13). The surveys do not include students in private schools, in institutions, those being home schooled, those absent from school, or school drop-outs.

There is reason to think that school drop-outs and those at risk of leaving school are either at higher risk, or are already regular or heavy users,[10,11] so it is important to understand the particular circumstances of these young people. While less is known about the substance-use patterns of "out-of-the-mainstream" youth, information is available from two multi-site studies,[12,13] as well as from individual studies from Toronto,[14] Halifax,[15] Vancouver[16] and Montréal.[17,18] Data from cities reporting to the Canadian Community Epidemiology Network on Drug Use (CCENDU), which annually brings together substance use harm indicators in 12 cities across Canada, have also been used.[19,20]

Recent Trends in Use

The most commonly used substances among youth are alcohol, tobacco and cannabis (marijuana, hash, hash oil). Ontario's Addiction Research Foundation (now the Centre for Addiction and Mental Health) has sponsored the longest ongoing Canadian survey of youth substance use. This series of surveys has shown that, after peaking in 1979, use of most substances by young people declined steadily until the early 1990s. Since then, the use of legal and illegal drugs by students has generally been on an upward trend.

Findings from the 1999 Ontario Student Survey on Drug Use (OSDUS) indicate that most drug use levels (with the notable exceptions of alcohol and tobacco, which have shown an overall decline) are now similar to those of the late 1970s – historically the peak period for use.[21] Increases in cannabis use over the 1990s have been found in Newfoundland and Labrador, Nova Scotia, Ontario, Manitoba and British Columbia[22,23,24,25,26] and have also been reported in a recent national survey.[27] Notably, the 1999 estimate for use of hallucinogens other than LSD, (e.g., psilocybin, mescaline) and methamphetamine among Ontario students is significantly higher than at any other time in the past 20 years, including 1979 (14% vs. 5% and 5.3% vs. 3.6% respectively). Nova Scotia has also seen an increase in hallucinogen use during the 1990s. Nationally, among Grade 10 students, use of a number of substances – cannabis, LSD, amphetamines, cocaine and inhalants – increased between 1990 and 1998.[28]

During all periods studied, less than 10% of the general high school populations surveyed in any of the jurisdictions were current users (i.e., any use in the past year) of stimulants, inhalants, cocaine, methamphetamines, Ecstasy, "ice" (crystal methamphetamine), tranquillizers, PCP, or opiates (e.g., heroin, fentanyl). However, past year Ecstasy use increased eight fold (from .6% to 4.8%) between 1993 and 1999 among Ontario students surveyed. It is also important to bear in mind that particular sub-groups – for example, older male students – are more likely to use most of these substances and have exceeded these rates in most cases. Other substances used by less than 10% of students are amphetamines, barbiturates and benzodiazepines – legal medications that are used non-medically. There is concern about the abuse of these drugs, but not where they are prescribed by a physician and used as directed.

Generally, the first use of alcohol, tobacco and cannabis by students appears to be occurring at a later age now than in the past. To illustrate, 13% of 7th graders in 1999 drank alcohol for the first time by Grade 4, compared with 17% of 7th graders in 1981. Similarly, 2% of 7th graders in 1999 used cannabis by Grade 6, compared with 8% in 1981.[29]

However, attitudes have become generally more tolerant of use, with fewer students expressing moral disapproval or perceiving a risk of harm in experimenting with various substances. Between 1991 and 1999, the percentage of students in Ontario strongly disapproving of the use of cocaine once or twice dropped from 55% to 42%; and strong disapproval of using cannabis once or twice dropped from 43% to 26%. The percentage of these students attaching great risk to trying cannabis once or twice declined from 31% to 18%. The same trend in attitudes has been found in the United States.[30]

Reports of problem use have risen in recent years. Since the early 1990s, there has been a general increase in the percentage of students reporting current use of more than one substance, including use of multiple illicit substances. For example, the percentage of Ontario students reporting current use of four or more substances more than doubled between 1993 and 1999 (from 8% to 17.4%). In Newfoundland and Labrador, the number of students using alcohol, tobacco, and cannabis increased from 1996 to 1998. The percentage of Nova Scotia students who consider themselves current users of these three substances doubled (from 12.4% to 24.9%) between 1991 and 1998. There tends to be a strong association between cigarette and cannabis use, with most who smoke cannabis also being cigarette users.

Significantly, since 1993, there has also been an increase in the percentage of Ontario students who engage in heavy drinking episodes (five or more drinks per occasion) from 30% to 42% in 1999. This pattern also occurred in British Columbia where the percentage of youth drinkers that reported heavy drinking episodes in the past month increased from 36% in 1992 to 44% in 1999.

As well, most indications point to an increase in the amount of frequent drinking during the 1990s. For example, in Ontario, the number of drinkers consuming alcohol at least once a week has increased from 14% in 1993 to 20% in 1999. Between 1991 and 1998 in Nova Scotia, the percentage of students who consume alcohol more often than once a month increased by 30% (from 25% to 33%).

Frequency of cannabis use has generally increased across the country during the past decade. To illustrate, the percentage of students in Nova Scotia who use cannabis more often than once a month tripled between 1991 and 1998 (from 4% to 13%).

An exception to this pattern of rising problematic substance use among students is the prevalence of driving after drinking, which, for example, has declined significantly between 1977 and 1999 (from 58% to 16%) in Ontario.

It is difficult to identify general trends in use of substances by out-of-the-mainstream youth because this population is quite fluid and information is incomplete. Toronto investigators reported a decrease in drug use, including injection drug use, among Toronto youth between 1990 and 1992.[31] However, these young people continue to be at risk for an array of health problems, particularly HIV, and hepatitis B and C as a result of injection drug use and needle sharing.

Current Patterns of Use

General Prevalence

In the late 1990s, on average, one-third to one-quarter of Canadian high school students (i.e., age 12-19) used no drug (including alcohol or tobacco) in the previous year (i.e., "current use"). Alcohol is the most commonly used substance by youth, with about two-thirds of all junior and senior high school students having consumed alcohol in the past year. The next most used substances are tobacco and cannabis, with roughly one-in-three students using these substances (40% use cannabis in British Columbia).[32] The fourth most commonly used drug class is hallucinogens, used by between 9% and 14% of students, depending on the province (with LSD used by 6% to11%).

Fewer Canadian students use other substances, with between 5% and 10% reporting use of inhalants, stimulants (both medical and non-medical), and typically fewer than 5% reporting use of cocaine, methamphetamine, heroin, PCP and non-medical use of other medications. Non-medical use of stimulants, tranquillizers and barbiturates is an issue, with roughly 3% to 10% of students considered current users of these substances in recent Canadian surveys. It is important to note these figures represent averages for the full junior and senior high school population and that prevalence of substance use increases with age.

The use of "club drugs", such as Ecstasy, methamphetamine, Rohypnol, GHB and Ketamine, has come to public attention. The Ontario student survey provides the only province-wide indication of Ecstasy use in Canada, with 4.4% of all students (ranging from 0.6% of Grade 7 to 9.8% of Grade 11 students) reporting past year use. This represents a significant increase from 1993 when 0.6% of students reported use. There is no Canadian information on the prevalence of other club drug use.

Limited information is available on injection drug use by students. Analysis of the 1999 Ontario survey found 2.5% of students reporting injection drug use,[33] while approximately 2% of students injected drugs in Nova Scotia and PEI.[34]

Substance use is just one of many problems faced by street youth. For these youth, substance use differs in that it serves more as a way of coping with negative experiences (both before and after going to the street) and has less of a recreational purpose. Prevalence and patterns of substance use by urban street youth in Canada vary from city to city, but according to the limited information available, appear much higher than student use. A 1992 study of Toronto street youth found that only 11% surveyed did not use any drug in the year prior to the study.[35] The study determined that 83% of these youth used cannabis in the past year. A 1995 survey of street youth in Montreal found that around 80% of street youth report having consumed alcohol and cannabis in the past month.[36] The Halifax study (1993) found that 66% of the sample used cannabis.[37]

The use of hallucinogens is more common among street youth than among students. In Toronto, 59% used LSD in 1992, nearly half of Montreal street youth used these drugs (1995), and 63% reported using LSD in Halifax (1993).

Similarly, the prevalence of crack and cocaine use by street youth in various cities is much higher than student use, estimated at 31% for both crack and cocaine in Toronto in 1992,[38] 20% and 33%, respectively, in Halifax (1993)[39] and 85% for cocaine in Vancouver (1994).[40]

Compared with student populations, the use of injection drugs among out-of-the-mainstream youth is also considerably higher. A study conducted with street youth in Montreal found that 36% had used injection drugs in their lifetime, and 23% had injected in the previous six months.[41,42] In Toronto, 28% reported having injected drugs at some time in their lives,[43] 17% in Halifax,[44] and in Vancouver 48% of males and 32% of females reported lifetime drug injection.[45] In a recent study conducted in seven major Canadian cities with street youth who identified their ethnic origin as Aboriginal, 21% of participants had injected drugs.[46]

There is evidence to suggest that rural or smaller town street youth use substances for the same reasons as their urban counterparts, but use alcohol predominantly, and other drugs to a lesser extent.[47]

Age at First Use

Early onset of alcohol and tobacco use has been associated with later substance use problems. For example, a recent large US study found that age at onset is a powerful predictor of later alcohol abuse and dependence. The study found that 40% of those who began drinking alcohol at 14 years of age or younger experienced alcohol dependence at some point in their lives, in contrast to roughly 10% of those who began drinking at age 20 or older.[48]

Most people begin smoking tobacco in pre- or early adolescence (only 14% begin after 20 years of age) and the risks associated with early onset of smoking are clear. The earlier young people begin smoking daily – an indication of dependency – the more cigarettes they are likely to smoke, the less likely they are to quit and the more likely they are to be heavy smokers as adults.[49]

Age at first use of alcohol appears to vary considerably from region to region;[50,51] however, it appears that a significant minority of young people have at least experimented with alcohol use by Grade 7. First use of cannabis occurs for a significant number of Canadian youth in Grades 8 and 9. First use of other substances typically occurs in subsequent years.

There is limited information available on the average age at which individuals start to inject drugs. In the Montreal study of street youth, females tended to start injecting at a younger age than males (16 years vs. 17.3 years).[52,53] Surveys of adults involved in injection drug use provide further information on age at onset. Research conducted in Nova Scotia,[54] Winnipeg[55] and Calgary[56] have reported overall mean age of first injection to be 21 or 22 years.

Initial use of inhalants appears to generally occur in the pre-adolescent years among those that ever use these substances. Alcohol and tobacco are generally the next substances used, with the average age of first use reported to be age 12 in Ontario.[57] One national study showed two-thirds of Grade 6 students having tried alcohol.[58] Initial use of cannabis appears to occur in the 13-14 year age range.

Age Differences

With the exception of inhalants, prevalence of substance use increases with age through adolescence. For example, the percentage of alcohol users increases sharply (in Ontario, from 40% to 84%) between ages 12 to 19, with the percentage of heavy users increasing similarly. The percentage of cannabis users rises dramatically with age, from under 5% among 12-year-olds to around 40% of 18 to 19-year-olds. Inhalants are the only type of substance where use is found to decrease with age: the percentage of inhalant users is highest among the youngest students and declines in subsequent grades.

This pattern of increased prevalence of use with age is clearly related to adolescent psychological development, during which independence and peer relationships assume greater importance.[59] Also, it is known that transition between school levels represents a point of vulnerability for some students. Consequently, it is possible that consumption rates may be affected by the differing points of transition between the traditional

elementary (Gr. 1-6), junior high (Gr. 7-9), and high school (Gr. 10-12) breakdown and the now more common breakdown of elementary (Gr. 1-5), middle school (Gr. 6-8), and high school (Gr. 9-12). The latter breakdown places Grade 9 students in the same environment as older youth and also brings a point of vulnerability down by a year.

Some users of alcohol and tobacco will go on to use cannabis; some of these will, in turn, go on to use other illegal substances. However, these and other studies show that progression to these other substances is far from inevitable. To illustrate: analysis of the most recent Ontario student survey data showed that about 90% of current cannabis users have not used cocaine.[60]

The prevalence of "riskier" substance use and problems associated with this use tend to increase with age. Consuming five or more drinks at a sitting and the likelihood of having been drunk increases with age, as does driving after drinking. Students are more likely to have one or more alcohol- or other drug-related problem as they get older and progress through high school.

Older out-of-the-mainstream youth in Halifax (those 18 and older) tended to use more alcohol than their younger counterparts. Heavy drinking increased markedly with age. This same pattern was evident with other substances, when, for example, 70% of the older group used cannabis heavily (once a week or more), while less than half (44%) of the younger group used at that level. In the Toronto study of street youth, youth aged 19 years and older were more likely to have engaged in injection drug use than younger youth (33% vs. 17%).[61] In the study with Montreal youth, injection drug use was equally prevalent among youth aged 12 to 15, compared with 16- to 19-year-olds.[62,63]

Peak Use

Given the age differences noted, it is not surprising that the peak period for substance use, with the exception of inhalants, occurs in the last years of high school. Prevalence of alcohol use by Nova Scotia students (1998), for example, increased from 21% in Grade 7 to a peak of 80% in Grade 12. The Ontario student surveys, which in the past sampled Grades 7, 9, 11 and 13 and now survey all grades, generally find that use of many substances peaks during Grade 11. In the 1999 survey, for example, prevalence of cannabis use increased from 4% in Grade 7 to 48% in Grade 11, declining to 43% in Grade 13 (the year in which some Ontario students pursue Ontario Academic Credits or OACs, for university entrance – to be phased out in the 2002-03 school year).

Gender Differences

When discussing differences in consumption between males and females, it is important to note that women have a lower threshold to the effects of alcohol. Nevertheless, gender appears to be a significant factor in student substance use. In the Ontario study (1999), male use was higher on 9 of 20 substances. The Atlantic Provinces surveys (1998) found males more likely to use most substances. To illustrate: 33% of male students used cannabis in New Brunswick (1998) compared with 28% of females. In Nova Scotia (1998), more males than females used LSD (12.7% vs. 7.6%). A common exception to this pattern is smoking, where in several jurisdictions, female smokers outnumber males.[64,65,66,67] Recent

surveys have also shown a higher percentage of females using non-medical stimulants (e.g., diet pills).[68,69] An exception to this pattern was recently reported in a study of Quebec adolescents that found women to be more likely than males to have ever used alcohol and every other substance, and as likely as males to have ever used alcohol or an illegal substance more that five times.[70]

Males are also more likely to engage in "riskier" forms of substance use. For example, males are almost twice as likely as females to drink at hazardous levels in Ontario and to use cannabis regularly in Nova Scotia. In both Nova Scotia, and Newfoundland and Labrador, males were twice as likely as females to drive after drinking.

Among out-of-the-mainstream youth in Halifax, males were more likely to drink, drink often, and drink heavily per occasion. With respect to other drugs, the gender differences were fewer.

Minimal attention has been given to the gender differences of young users of injection drugs. In the Toronto study of street youth, 30% of males reported lifetime injection drug use, compared with 23% of females.[71] However, in a study of youth in British Columbia correctional facilities, more young females (10.2%) than males (3.4%) reported injection drug use.[72]

Heavy Use

Significant numbers of Canadian youth engage in heavy substance use and, as already noted, these numbers appear to be increasing. Approximately one-third of high school students report having consumed five or more drinks on an occasion (considered heavy drinking) at least once in the past month. About 1 in 10 students drank alcohol once a week or more often. Heavy cannabis use (once a week or more) was reported by 1 in 4 users, with close to 1 in 10 reporting daily use. Daily cigarette smoking varies considerably from 1 in 10 in British Columbia to 1 in 5 students in Ontario. Estimates of rates of heavy use of other substances are generally not available.

Among street youth, there are indications that heavy substance use is common. Youth on the street are more likely to use substances with the intent of becoming intoxicated.[73] A Toronto study (1992) found that 63% of street youth consumed five or more drinks per occasion at least once in the previous month, with a significant portion of them (23%) drinking this amount on five or more occasions within that period. A similar proportion (65%) of a sample of Halifax out-of-the-mainstream youth reported consuming five or more drinks on days when they drank (1993).

Regarding drugs other than alcohol, 58% and 25%, respectively, of out-of-the-mainstream youth in the Halifax study were classified as heavy users of cannabis and LSD (i.e., once a week or more). Thirty-nine per cent of these youth were considered heavy users of cocaine (44% crack) with a significant proportion using these substances daily. In Montreal, 5% of street youth report using heroin every day (1995).[74]

Harmful Effects and Particular Risks Reported

Although a study of Quebec youth suggests a different pattern among youth in that province, alcohol problems are more likely to be reported by students than problems with other substances. In Ontario, more than 1 in 10 report drinking at what authorities consider a "hazardous level." Significant numbers of students report problems associated with drinking or other drug use. For example, nearly half of Newfoundland and Labrador students who drink report at least one problem associated with their drinking (1998). In Ontario (1999), 6% of all students reported experiencing two or more alcohol problems, while close to 4% reported two or more drug-related problems. Nationally (1994), around 1 in 4 15- to 19-year-olds report some type of harm connected to their drinking – more than twice the number for the population as a whole.[75]

A recent study of problem substance use among Quebec adolescents (between 14 and 17 years old) found that among the youth who had used an illegal substance more than five times (one third of the sample), a strikingly high percentage reported problematic use; for example, 80% of males and 70% of females had attended school drugged or high; 68% of males and 56% of females had used illegal drugs in the morning; and 75% of males and 53% of females had played a sport while under the influence of an illegal substance. It appears that while two-thirds of the sample either did not use an illegal substance or had used experimentally, problematic use is the norm among the remainder of the youth.[76]

In the case of both students and out-of-the-mainstream youth, heavy users tend to use more than one substance, incurring risks for various problems due to the additive or synergistic effects of combining different drugs. In Newfoundland and Labrador (1998), 23% of students were current users of alcohol, tobacco and cannabis. Ninety per cent of Grade 10 daily smokers in a national study had also used cannabis.[77]

Causing damage to property and causing injury to oneself, are among the most common problems associated with substance use reported by students. Sexual activity associated with substance use has significant implications. Among sexually active students in Prince Edward Island, (the only jurisdiction reporting on this issue) over half engaged in unplanned sex while under the influence of alcohol or other drugs. About 1% of students report having been in treatment for alcohol or drug problems in the past year.[78,79]

Because heavier use is more common among out-of-the-mainstream youth, more problems can be expected. Half of the youth in the Toronto study of street youth (1992) reported at least one alcohol problem and one drug problem. Twenty-five per cent of the Halifax sample (1993) felt they had a problem involving alcohol and/or other drugs. Among those acknowledging a problem, 59% indicated they had attempted to get help. In the case of the Toronto sample, 46% had received some form of treatment.

Injection drug use is prevalent among street youth. A Montreal study (1998) found the percentage of injection drug users among a sampie of close to 1,000 street youth to be very high (36%).[80] Injection drug use and the practice of sharing needles place youth at risk of infection with HIV and other bloodborne viruses such as hepatitis C. In the Montreal

study, needle sharing was common and seemed to occur soon after initiation of injection drug use. In a BC study of young offenders, injection drug use was a strong predictor of other high-risk behaviours such as trading sex for money or drugs and sex with other injection drug users.[81]

Conclusion

Population surveys provide a broad estimate of substance use patterns in a given jurisdiction at a particular point in time. These patterns are constantly changing due to a number of factors, so the accuracy of these estimates can be expected to erode with time. It is always useful to conduct a local assessment of use and problems; however, population surveys can provide a useful starting point for understanding local youth substance use and making decisions concerning the level, timing and aims of prevention efforts.

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Section 3

Principles of Effective Substance Use Problem Prevention Programs for Youth

The following principles are recommendations for effective programming to prevent and reduce substance use harm among youth. The principles represent a consensus by the project team and steering committee on the basis of evidence from the scientific literature. In our opinion, the more fully they are reflected in a program, the more likely the program will be effective. Sponsors thinking of adopting a "packaged" program may benefit from using the principles to gauge the program's potential effectiveness, rather than blindly adopting the program. Those developing a program to address local circumstances should use the principles to guide their work. Finally, the principles may be useful in reviewing and strengthening an existing locally devised program. The principles and their categories are:

Build a Strong Framework

Address protective factors, risk factors and resiliency: Focus on the factors that most directly promote resiliency or, conversely, contribute to substance use problems in the population of interest.

Seek comprehensiveness: Tie activities to complementary efforts by others in the community for a holistic approach, and seek support through agency policy and municipal and other government regulation.

Ensure sufficient program duration and intensity: Make certain there is sufficient contact time with participants; age appropriate coverage needs to occur through childhood and adolescence and needs to be intensified as the risk of participants increases.

Strive for Accountability

Base program on accurate information: Base program aims on reliable and, ideally, local information on the nature and extent of youth substance use, problems associated with use and user characteristics.

Set clear and realistic goals: Set goals, objectives and activities that address local circumstances, are linked logically and are measurable and time-limited.

Monitor and evaluate the program: Evaluate the process and impact of efforts and ensure that costs are in line with program benefits.

Address program sustainability from the beginning: From the outset, work toward long-term sustainability and integration of the program into the core activities of the relevant organization in the community.

Understand and Involve Young People

Account for the implications of adolescent psychosocial development: See substance use issues within the context of the stages of adolescent development in order to respond most effectively.

Recognize youth perceptions of substance use: In order to be credible with participants, programs need to take account of the way young people view the benefits and the risks associated with substance use.

Involve youth in program design and implementation: Young people need to see themselves, and to be seen by others, as their own best resource for minimizing any harm associated with substance use.

Create an Effective Process

Develop credible messages: Both the explicit and implied messages delivered in a program need to be viewed as realistic and credible by participants.

Combine knowledge and skill development: Skill development needs to be a central element in programs and it needs to be accompanied by accurate, objective information.

Use an interactive group process: Engage and involve participants in skill development activities and discussions.

Give attention to teacher or leader qualities and training: Select and train leaders or teachers who demonstrate competence, empathy and an ability to promote the involvement and interaction of young people.

Build a Strong Framework

Address Protective Factors, Risk Factors and Resiliency

> **Focus on the factors that most directly promote health or, conversely, contribute to substance use problems in the population of interest.**

In the past, we've acted on the assumption that young people used substances because they didn't know any better. While lack of good information can be an issue, the reason why young people use substances is more complicated. In addition to using for some of the same reasons that adults use (e.g., to relieve stress and to escape emotional pain), young people may try using substances for a variety of other reasons, including, to show independence, signal entry into a peer group and to satisfy curiosity.

The reason why some youth experience problems in relation to their use of substances is also more complicated. Substance use problems usually arise from a combination of individual-, family-, school- and community-related factors. The terms "protective" and "risk factors" are

often used to identify aspects of a person and his or her environment that make the development of a given problem less (i.e., protective factor) or more likely (i.e., risk factor). Risk factors, protective factors and resiliency are interrelated concepts that are important considerations in understanding the target population and in designing a program.

A body of international research indicates that the general health status of a society is heavily influenced by the social, economic and physical circumstances of its people (i.e., employment, income, and educational levels, working conditions, social status, the degree of social support experienced, and early childhood nourishment and care).[1] From a population health perspective, these factors can be viewed as overarching factors or determinants of health that can be influenced by economic and social policy and may affect the use of substances.

Substance use-specific research shows that societal and community-level factors include the prevailing social norms and attitudes toward substance use, the prevalence of crime in a neighbourhood, the price and availability of various substances, and economic conditions. Factors arising from the family environment include a history of substance use problems, the effectiveness of family management, structure and coping strategies, the level of parent-child attachment, the nature of rules and parental expectations, and the strength of the extended family network.

At the level of the individual, persons may be predisposed to substance use problems due to genetic and/or environmental factors, but neither set of factors will, in and of themselves, determine the outcome. It is very important that a child experience stable support and care from a parent or other adult from an early age. The quality of a child's school experience is a very significant factor for substance use problems and a number of other problems. Influences on the school experience include academic success, reading skills, problem-solving abilities, feeling a part of the school scene (as opposed to feeling alienated) and participation in extracurricular activities.

As a child enters adolescence, the selection of peers and nature of peer support become more important. Anti-social behaviour, such as violence and gang membership, is a risk factor, as is having friends who use substances. Transitions or significant changes in one's environment (e.g., moving to a new neighbourhood or school, bereavement, parental separation) can be a significant point of vulnerability for young people.[2] General personal and social competence is critically important. It is reflected in the feeling of control over one's life, feeling optimistic about the future, being able to detach from conflict in the home or neighbourhood, and being willing to seek support from outside the immediate family (e.g., from an outreach worker or drop-in centre).[3]

The more risks that a child or youth experiences, the more likely that substance use and related problems may occur. These risks are dynamic and interplay with the strengths and assets available to a person. Resiliency is a concept that helps in understanding this interplay. It has been observed that some people growing up in difficult circumstances fare better than others, and it has been suggested that they are more resilient.[4]

Resiliency is the ability to cope with adversity or a situation that is not readily amenable to change (e.g., living with an alcohol-dependent parent). The crucial feature of resiliency is the ability to cope, which, in part, is innate, but can be enabled or strengthened through

appropriate social support. This capability changes over time, is enhanced by protective factors in the individual and the environment, and contributes to the maintenance and enhancement of health. When risks are greater than the individual's protective factors, then even individuals who have been resilient in the past may experience problems. The balance is not determined solely on the basis of the number of protective and risk factors present in the life of an individual, but on their respective frequency, duration and intensity, as well as the developmental stage at which they occur.

These same attributes have been extended to describe resilient families and communities. For example, resilient communities have been shown to adapt and come together in a mutually supportive way in the face of an adversity such as the collapse of the local economy.[5] Promoting resiliency and strengthening protective factors in people is seen by many as preferable to focusing on their deficits and problems.[6,7] However, focusing on promoting resiliency in children so that they can cope with various adversities may cause people to neglect the important work of reforming unhealthy environments.

Out-of-the mainstream youth is a term used to refer to those who are either homeless or have only a tenuous home connection, and often adopt a high-risk lifestyle that includes heavy drug use and other health risk behaviours. One Canadian study found that 60% of female and 47% of male out-of-the-mainstream youth left home to escape a family situation characterized by conflict, abuse or parental alcohol or other drug problems.[8] Many school dropouts experience alienation in the school system even though they may have satisfactory academic records.[9] The tendency of schools to expel students involved in drug-related incidents can contribute to social exclusion and increase the risk of more severe drug problems. Often, participation in illegal activities is driven by the need to meet basic needs and support a drug habit.[10,11]

A clear advantage of the protective/risk factor approach is the understanding that many social and health problems are linked by the same root factors – an understanding that can lead to better integration of strategies and economizing of resources. However, because a factor is linked to substance use problems does not necessarily mean that it causes such problems. Consequently, the actual preventive effect of addressing one or another of the protective or risk factors is not very clear and no doubt varies between the factors.[12] Nevertheless, it appears that addressing protective or risk factors in several domains of a young person's life (i.e., individual, school, family and community) can lead to positive outcomes.

Seek Comprehensiveness

> **Tie activities to complementary efforts by others in the community, and seek support through agency policy and municipal and other government regulation.**

Research indicates that comprehensive programs (i.e., those involving multiple components and domains) are much more likely to be effective than single-focused activities. Because of the range of factors that can contribute to substance use problems, it is important that communities or programs identify and address relevant factors through a number of activities

that are well coordinated. Families and schools are critically important domains in youth substance use problem prevention. It is better still when others complement their efforts at the community level, including the media, youth agencies, sports and arts groups, communities of faith and municipal governments.

Community coalitions or other planning bodies need to consider a range of complementary policies and services targeting youth. The coordination of different interventions can be accomplished in a number of settings or within a single organization or agency. For example, schools can combine classroom instruction, peer helper programs, parent education, school policies and mentoring for at-risk students. Municipalities can coordinate recreation programs, community policing and neighbourhood support programs. Joint planning in community coalitions will avoid duplication of services and increase the resources that can be brought to an initiative.

Comprehensiveness also means giving attention to organizational policies (e.g., school board or youth agency) to ensure they reinforce program aims.[13,14] A recent review did not find evidence of added effect from policies intended to influence the environment (many of the studies reviewed did not attempt to single out any positive effect of the various elements, such as media, and parent training).[15] However, the current consensus among experts is that policies need to reinforce programming. At the broader level, legal and regulatory measures (e.g., price increases, server training programs that give attention to underage drinkers, enforcement of minimum purchase age laws) need to be considered as they have demonstrated effectiveness in reducing youthful alcohol-related harm.[16]

Comprehensiveness challenges programmers to see their prevention initiatives as contributing to a series of interventions that present developmentally appropriate messages throughout childhood and adolescence. For example, school prevention efforts need to be ongoing from kindergarten to secondary school, allowing messages to be repeated and reinforced. Comprehensiveness in a community also means ensuring that the various parts of the youth population – from lower risk to higher risk – are being served (see the next section on target populations).

Programs for higher risk youth may be situated in multi-service centres or other settings, such as emergency wards in hospitals, health clinics (e.g., for expectant adolescent women), and in shopping malls and on the street. Police and the courts have an opportunity to intervene and divert young people to prevention or treatment programs in the community. A comprehensive approach to programming for higher risk youth may call for the attention and collaboration of some who haven't traditionally played a role in preventing substance use problems, such as urban planners, housing authorities, shopping mall management and employment policy makers.[17]

Street youth indicate that they have important basic needs. Food and stable housing are basic requirements for getting off the street; job training, educational upgrading and personal counselling are also important.[18,19] The needs of youth involved with injection drug use may be greater still.[20] Young injection drug users are often involved in multiple drug use, with their daily activities revolving around the acquisition and use of drugs. Involvement in illegal

activities is often a means of meeting the financial demands of their drug use, often to the detriment of basic subsistence needs. These realities necessitate a comprehensive prevention and harm reduction approach that gives attention to the environment in which unsafe behaviour occurs, and to the provision of basic needs.

At a broader level, the protective and risk factors associated with substance use problems may also be factors linked to other problem behaviours. For example, in some communities, poverty, particularly if associated with a dysfunctional lifestyle, has been shown to be a risk factor not only for substance use problems, but also for pregnancy and violence among young people. Similarly, difficulties in school are associated with a number of social problems among youth, including substance use problems.[21,22] Prevention efforts that address broad risk factors are a means of supporting and integrating with other strategies that aim to improve the lives of people and communities.[23] On this basis, a substance use problem prevention plan or strategy might be embedded within a larger crime prevention, safety or health promotion initiative.

Ensure Sufficient Program Duration and Intensity

> **Make certain there is sufficient contact time with participants; coverage needs to occur through childhood and adolescence and needs to be intensified as the risk of participants increases.**

The general level of use, particularly problematic use, is an important consideration in determining the overall level of the preventive effort required in a community. In Ontario, the only Canadian jurisdiction with long-term trend data, the current levels of substance use and problematic use are close to the levels seen in the late 1970s, which were the highest in the past 20 years.[24] Also, most evaluations show that as time passes, program effects erode and need to be replenished.[25] Given this, preventive efforts need to provide coverage through childhood and adolescence or at least be coordinated with others to create this effect.

As well as an understanding of the nature and extent of youth substance use locally, it is important for prevention planners to account for local protective and risk factors to clarify their targets and to more precisely gauge program intensity and duration. As a rule, the higher the risk for a group or sector of the population, the greater the needed intensity in the preventive effort.[26] In North America, target groups for preventive initiatives are increasingly being classified according to risk level (i.e., universal, selective and indicated targets), a framework that is seen as more discriminating than the terms primary and secondary prevention.* Program focus, intensity and duration need to vary according to these target groups.

Universal Prevention

Preventive activities can target a broad or "universal" population (e.g., all students in Grades 5 and 6) with the aim of promoting the health of the population, or preventing or delaying the onset of substance use. Children and youth are often the focus of universal preventive efforts intended to address risk factors and practices relating to traffic crashes and other trauma, unwanted pregnancies, suicide, and other short or long-term health and social problems. Parents and families are another priority for universal prevention, largely

due to their role in supporting the healthy development of children and the challenges many experience in balancing family and work commitments. Measures often associated with universal prevention include awareness campaigns, school drug education programs, multi-component community initiatives, and, in the case of alcohol and tobacco, various measures to control their availability and price.

Schools are a strong setting for universal programming for youth and should provide appropriate programming in all grades. Given that a significant number of children have initiated use by age 12, primary preventive efforts need to give particular attention to 9- and 10- year-olds before use begins. For Universal youth programs, a minimum level of intensity is usually one 45 to 60-minute contact a week for at least 10 weeks.[27] Programs that provide "booster" sessions in subsequent years to reinforce earlier lessons have been shown to be more effective.

While parents should be encouraged to become involved in broad preventive efforts, they, of course, have a crucial part to play in preventing substance use problems through their role as parents. Parental monitoring of children's behaviour and strong parent-child relationships are also positively correlated with decreased drug use among students.[28] Parenting programs can support this role, by addressing such issues as: clarifying and explaining values to their children, modeling healthy behaviours, understanding children's needs and self-concept, communicating effectively with their children, developing problem-solving skills, providing appropriate reinforcement and consequences, use of behavioural contracts, and fostering a democratic environment in the family.[29] Parents also need to acquire accurate information on the various substances of abuse and their effects, so they can discuss them knowledgeably with their children.

Parenting programs typically have difficulty attracting parents. It has been suggested that parent information, education and support need to be "normalized" by making them widely available through media, information lines, and work site and school programs.[30] It has also been suggested that programs be entrenched in a neighbourhood and available over the course of a number of years rather than the more typical "one-off" sessions. Parents are more likely to be engaged in a parenting program if it is perceived as being established and having a good track record. Many parents may benefit from help on communications, coping and disciplinary skills in a brief one- or two-session program.[31]

These broad, lower-intensity efforts aimed at the population in general can serve to "till the soil" by creating greater awareness of the issue and acceptance of the need for more targeted programs.[32] Similarly, they can lead some individuals to contemplate changing risk behaviours and to present themselves for more intensive programming.[33]

Selective Prevention

Some youth and their families experience particular challenges due to academic problems, family dysfunction, poverty, and family history of substance use problems (that may include genetic predisposition). It makes sense to "select" such persons or families for more intensive programming on the basis of these risk factors. Selective prevention aims to generally reduce the influence of these risks and to prevent or reduce substance use problems by building on strengths such as coping strategies (a personal resiliency

attribute) and other life skills. Children in difficult environments clearly benefit from selective prevention interventions at the pre-school and early school years. Early childhood education programs that involve and support parents in nurturing their children, and that include home visits, have shown evidence of effectiveness in preventing substance use and other later problems.[34,35] Adolescent males are currently more likely to use substances in risky ways than females. Prevention settings that have the opportunity to direct attention to males particularly need to be alert to those opportunities.

Family-based approaches appear to hold particular promise for higher-risk children and youth. These approaches are generally designed to improve family functioning and reduce various anti-social behaviours, including the risk of problematic youth substance use. As mentioned above, recruitment and retention are typically challenging with family-based programs. Such groups as Children's Aid Societies and Boys and Girls Clubs may provide contacts for parents of higher risk children. Facilitating development of bonds among parent participants has been suggested as a promising way to retain parents in these programs.[36]

Although selective programs tend to be more efficient than universal programs in effecting change among at-risk youth, there are important disadvantages that need to be considered; for example, the possibility of labelling and stigmatizing, difficulties with screening, and not enough attention on the community-wide social context as a focus of change.[37]

Indicated Prevention

Some young people who are using substances regularly will not as yet have met the criteria for dependency, but are at high risk of doing so. These youth usually experience an array of other health and social problems and benefit from indicated prevention programming that is typically more intensive still. Indicated prevention often involves an outreach component to identify, engage and work with these youth to minimize the harm associated with their lifestyle.

A small percentage of students experience a number of significant problems, including those stemming from substance use. For these young people, counselling or more intensive treatment based on sound assessment is important. A range of other services (including intervention, case management and referral to address various issues) is often necessary for these students and needs to be available from schools or community agencies.

With higher risk families, family therapy has been shown to be an effective component of a comprehensive strategy. Family therapy helps family members develop interpersonal skills and improve communication, family dynamics, and interpersonal behaviour. It can be used to help family members improve their perceptions of one another, decrease negative behaviour, and create skills for healthy family interaction. Therapy can also help to enhance parenting skills and reduce inappropriate parental control over children.[38]

Out-of-the-mainstream youth that are using substances in risky ways need support in a number of areas of their lives, other than substance use. The focus of activity needs to be in minimizing harm in the context of the day-to-day challenges facing these young people. Street youth indicate that having a decent place to live is, by far, the most important factor

in getting off the street.[39] Opportunities for leisure, recreation, community service or alternative schooling have been found to be helpful with some higher risk youth. Termed the "alternatives approach", these opportunities may be most appropriate for youth who cannot be accessed through schools, and those who do not have adequate adult supervision or access to a variety of activities.[40] Some of these young people may be characterized as sensation-seekers and may respond well to alternative programs that offer excitement and adventure.[41] This experience may motivate some to participate in counselling or other forms of treatment based on sound assessment.

Caution must be exercised in working with high-risk youth, as bringing them together into new groups can in some cases increase substance use. It has been speculated that participants in these groups may tend to validate and legitimize the anti-social behaviour of other group members.[42]

Injection drug use poses several serious risks (i.e., overdose, HIV and hepatitis C infection) and warrants intensive preventive efforts. Young people may be particularly susceptible because of relative inexperience, faulty knowledge and pressure from older users of injection drugs. Conventional approaches for reaching youth and providing prevention programming may not be appropriate for this population. Rather, creative outreach approaches, involving peers, offer more success. Also, research suggests that increasing access to new, sterile injection equipment may eliminate one of the more significant contributors to injection drug use risk and needs to be a program priority.[43,44] Safe injecting facilities may reduce overdose deaths while reducing transmission of blood-borne infections and minimizing public nuisance. While some centres outside Canada have implemented these types of measures, and others are investigating their potential for reducing risk of overdose and other health problems, they remain controversial and their cost effectiveness is at this time largely speculative.[45,46]

While indicated programs are clearly required to address more advanced substance use problems, they also tend to be the most costly to develop and implement (though efficient in reaching the appropriate target group). Challenges in recruitment and retention are not uncommon. Ideally, a combination of universal, selective and indicated programs will be available in a given community and will vary with the community.[47]

Strive for Accountability

Base aims on reliable and, ideally, local information on the nature of youth substance use and problems associated with it.

Base Program on Accurate Information

Accurate information on the nature and extent of substance use and associated problems is a critically important basis for prevention program development (see Section 2). Data can help determine the point at which a significant portion of a population has begun to use occasionally, or regularly, and can indicate the substances of greatest concern. To be most

effective, youth preventive programs need to match their goals, activities and messages to these specific circumstances. For instance, if a significant portion of a youth population is currently using alcohol frequently and heavily, a program based on reducing the harm associated with this risky use of alcohol makes most sense.

Large prevalence studies, conducted at regular intervals within a jurisdiction, are very useful in estimating the nature of substance use in that jurisdiction. Information of particular value to programmers is: age of first use of a significant portion of the population, age and gender differences, age of peak use for most youth, and problems reported. Prevention programmers also need to seek out more local indications of the nature and extent of substance use in their community (e.g., police and emergency room data). The Canadian Community Epidemiology Network on Drug Use (CCENDU) supports a number of Canadian communities in developing a profile of drug use in their communities. Each community in the network brings together local experts (e.g., public health, emergency ward, police, and treatment specialists) to contribute quantitative and qualitative information that is relevant to local needs and easily updated.[48] Prevention and health promotion workers are also learning from First Nations peoples and using structured narratives or story telling to gather qualitative information on what is occurring within a community.[49]

Regular ongoing reviews of the nature and extent of substance use among the population of interest will help to evaluate program efforts and lead to adjustment of aims and activities accordingly.

Set Clear and Realistic Goals

> **Set goals, objectives and activities that address local circumstances, are linked logically, and are measurable and time-limited.**

Clear and realistic goals that logically link program activities to the problems and factors found in a community are necessary to guide implementation. Clear and measurable goals will permit evaluation to determine whether the program achieved its objectives. Goals will vary with the community and the circumstances; however, important considerations for all programs are the points at which use and problematic use of different substances generally begin. Drawn from youth survey findings, this information allows preventive efforts to be more precise with both goals and messages.

Program efforts aiming to prevent or delay the age of initial use need to be timed to occur before any significant percentage of youth have tried the substance. Although circumstances may vary in particular communities, various Canadian studies (see Section 2) suggest the appropriate timing for efforts to prevent or delay the onset of use is currently as follows:

- At younger ages (Grades 1-3), there is little use of illegal substances, so there is little need to give attention to these substances. For this age group, goals need to focus on safety concerns and sensible use of medications (e.g., headache pills, pain relievers) and other potentially hazardous household products.

- An exception to this is in communities where inhalant use occurs. In these communities, information on inhalant use needs to begin in the 6 to 9-year-old (Grades 1-3) period, given the younger age of onset of inhalant use. Because of the potential immediate and long-term harm involved, goals need to centre on preventing use of inhalants through more intensive educational programming. Counselling is justified for those students who are using or are at risk of using inhalants.
- For many youth, the first substances used are tobacco, alcohol and cannabis at or prior to ages 12 and 13. Consequently, prevention activity aiming to prevent or delay onset of use of these substances needs to begin at age 9 or 10 (Grades 4 or 5). Children at this age are generally not using or considering use of illegal substances, so specific attention to fully illegal substances other than cannabis may not be needed until age 12 or 13.
- Grades 7 and 8 (usually ages 12 and 13) are particularly important years for substance use problem prevention for a number of reasons. Typically, drug use increases significantly between middle school and secondary school, and students are more vulnerable due to developmental changes and changes in school, friends, academic pressures, and their environment (e.g., greater accessibility of various substances). Intensive preventive efforts need to be focused during these years, prior to the transition to secondary school.

Program efforts aiming to minimize the harmful effects associated with heavy or risky substance use need to occur before significant numbers of youth use substances in this way, which currently in this country is generally as follows:

- At age 15 (Grade 9 or 10), the majority of students have tried alcohol, approximately 1 in 4 have used tobacco and cannabis, and 1 in 10 have used a hallucinogen. Moreover, significant percentages of this population engage in potentially harmful patterns of use (e.g., using frequently, using heavily per occasion, or driving after using). Preventive activity for ages 15 to 18 (Grades 10-12) needs to be aimed at reducing risk of harmful effects arising from potentially harmful substance use patterns.

A "stages of change" model, originally developed as a strategy for guiding treatment processes, can also help to conceptualize prevention goals based on particular characteristics of the target population.[50,51,52] This model, as it applies to prevention, proposes that individuals pass through several stages in deciding to use a particular substance:

- Pre-contemplation: not considering use
- Contemplation: thinking about initiating use
- Preparation: intending to use
- Action: initiating use
- Maintenance: continuing to use

Accordingly, for youth who are not yet using (i.e., either not considering use or thinking about use) the program aim would be primary prevention. Programs working with a population largely consisting of youth who have initiated use and continue to use, a secondary prevention or harm reduction aim makes most sense. Each of these aims logically lead to particular activities and messages (e.g., use of more intensive approaches with those using or preparing to use).

Goals can be refined and better evaluated by regularly polling youth participants on their "stage of change" for each substance of concern. For example, determining the percentage of youth no longer considering use (i.e., moving from contemplation to pre-contemplation) would be an appropriate focus for program goals and evaluation measures.

It is important to involve key groups, particularly youth participants, in the process of developing program goals.

Monitor and Evaluate the Program

> **Evaluate the process and outcome of efforts, and ensure that costs are in line with program benefits.**

It is difficult to demonstrate effectiveness in prevention programming. Research shows that the effects of many current programs are quite small – when they show any effect at all. Programs demonstrating evidence as a result of rigorous, controlled research need to be replicated with different sub-populations (i.e., different ethno-cultural groups) in various settings. While the need for prevention program evaluation has been noted for years, many preventive efforts remain unevaluated. Scientific evaluation is a specialized task requiring knowledge of experimental design and statistics, expertise that most preventive programs lack. This expertise tends to be expensive and most preventive organizations cannot afford the associated costs. Moreover, fears that the evaluation will put a program in a poor light or that it will divert attention and resources from the intervention are common. These barriers can be overcome if governments and other funding bodies give evaluation greater priority by highlighting the benefits of evaluation in continuously improving a program, and, most importantly, by offering technical and financial support (which is generally agreed to amount to at least 10% of other costs) for evaluation.[53]

Even without technical assistance, programs can document and evaluate their efforts. Two general forms of evaluation are process and outcome evaluations. Questions to be answered by a process evaluation are "How many people are coming? Are we reaching our target audience?" A mid-program focus group or questionnaire could determine satisfaction with the program. In this way, changes can be made early to meet the needs of the group and reach the desired outcomes of the program. The aim of outcome evaluations is to answer the question, "Did the program achieve what was expected?"

Although it has rarely been undertaken to date, it is also important to give consideration to program costs in relation to outcomes. In considering costs, an important issue is deciding what costs to include. One investigation distinguished between low, medium and high cost definitions for school drug education:[54]

- **Low cost = program materials + teacher training time:** argues that it is only necessary to account for costs that sponsors (e.g., school boards) don't already cover (i.e., materials and teacher training).

- **Medium cost = low cost + teacher salary while delivering program:** assumes that there is an opportunity cost due to teacher time being diverted from other subjects to the prevention program.
- **High cost = medium cost + facility costs:** assumes opportunity costs to the facility; this permits cost effectiveness comparisons with other drug demand reduction methods that usually include facility costs such as treatment and incarceration.

In investigating program costs, it is also important to consider who is bearing the cost. One source distinguishes among those costs borne by the primary sponsor, the partner agencies, and the participants:[55]

- **Direct costs to the agency delivering the intervention:** including easily determined costs such as brochures and telephone bills, but also less easily determined costs such as staff costs if they're involved in more than one activity, and capital and management expenses.
- **Direct costs to other agencies involved in the intervention:** support may be given in kind by other agencies such as volunteer time and donated resources, rather than in the form of monetary resources. They may be difficult to quantify, but if they have alternative uses, then they have some form of economic value.
- **Direct costs to the individuals participating in the intervention:** e.g., transportation costs or other expenditures by a family in order to participate in a program.
- **Indirect productivity costs to participants:** lost productivity as a result of participating in a prevention program.

Program research and evaluation costs need to be included in a full accounting.[56] Readiness of the community or target population may be seen as a variable – if the group to whom a program is directed is not engaged and motivated, participant recruitment will consume more effort and materials than if this was not the case. Several months of promotion may be required to give the program visibility and to encourage participation by young people.

There are early signs that prevention programs for youth can show modest cost effectiveness.[57] Beyond that, it may be that the broad application of several prevention programs in a population may have a cumulative positive effect that is less apparent in the evaluation of any of the specific programs.[58]

Address Program Sustainability from the Beginning

> **From the outset, work toward long-term sustainability, integrating the program into core activities of relevant organizations in the community.**

Too often programs are developed without a commitment of continued funding or without sufficient thought given to long-term viability. As noted above, program duration is a key factor in achieving sustained effects over time. Before any preventive initiative is started, planners need to determine the long-term implications. A formal work plan, time table and budget that

include defined responsibilities and long-term funding need to be developed at the outset. According to Rogers' theory of diffusion of innovation, sustainability issues should be addressed in the first stage (innovation development) before proceeding to the other stages of dissemination, adoption, implementation and maintenance.[59]

According to one model, sustainability requires continuous attention to four aspects of community work: the issue (putting a specific issue on the agenda for the public, the decision-makers, and the community partners); the program (that is being implemented in the community); behaviour changes (that may have resulted from the program); and the partnership (that was involved in and supports the program).[60]

An important first step toward program sustainability is the development of a program or service that the community wants or needs and the formation of partnerships to support it. Programs initiated by an individual agency or small group can be strengthened and supported by seeking additional partnerships at the outset. Partnerships can be built around specific issues of common concern, and may involve all levels of government, non-government agencies, volunteer groups and the corporate community as well. Steps to developing relevant partnerships can include: focusing on a specific community issue/concern, identifying partners who might be interested in working on the issue, identifying benefits for them to become involved, and developing a communications plan for the project and a strategy for involving new agencies and individuals.[61]

Other specific issues related to program sustainability that need to be addressed include availability of staffing, staff training, materials required, space needs, agency mandates, and time requirements.

These types of issues become barriers to adoption and to permanence if not adequately addressed in the early stages.[62] For example, program developers and planners are more likely to achieve success by ensuring that a prevention program is integrated fully into a school or community organization (or both). This means that "core" staffing would be assigned to implement the program, material costs would be included in annual budgets, and equipment and space needs would be allocated on a long-term basis. Within the school setting, substance abuse preventive programs must fit within the formal curriculum and structure of the school.

Once school or community agency personnel are assigned to implement the program, adequate ongoing training of the required staff will ensure that the expertise lies within the organization (as opposed to an external sponsor of the program). Because of the need to train new staff, to give refresher training to existing staff, and to train for program modifications, training must be seen as ongoing. Beyond that, even the provision of the training itself needs to be integrated into existing structures and organizations (e.g., appropriate teacher training can be integrated into pre-service curricula in university Faculty of Education programs).

Sustainability of an "issue" such as substance abuse can also serve to support program sustainability. For example, if the issue remains on the agenda of the public and key decision-makers, there is a greater likelihood of attracting longer-term funding, and maintaining long-term commitment of community partners. Activities such as communication campaigns, advocacy and awareness-raising activities can help to sustain the "issue".[63] In the substance abuse field, it is particularly important to educate the public with accurate data on

trends and issues. If the public responds to perceived "crises", the response may be strong, but short-lived. In order to maintain long-term support for their own program and for preventive efforts generally, sponsors need to both promote their own program, and also support messages emphasizing that substance use problems are not a one-time crisis, but rather an integral part of our society.

Understand and Involve Young People

Account for the Implications of Adolescent Psychosocial Development

> **See substance use issues within the context of child and adolescent psychosocial development in order to respond most effectively.**

An understanding of late childhood psychosocial development and the stages of adolescent development are important to consider when developing prevention programs. A major challenge in child and adolescent development is identity formation.[64] The extent of successful identity formation in childhood years has an important bearing on how well this process is achieved in adolescence.

Personal identity is a self-recognition that takes in one's attributes, desires and personal orientations and determines how people think, feel and behave. Self-concept and personal identity are inextricably linked, and a sense of being in control (i.e., one's self-esteem) depends on how well identity formation is proceeding.

Erikson and others have referred to the last phase of childhood identity formation as the "industry versus inferiority" stage. By the end of this stage, children should, through "industry", have acquired confidence in their ability to learn and become diligent in acquiring new knowledge and skills. Success in achieving these attributes through middle and late childhood will provide a good foundation for successful identity formation in adolescence. In this last childhood phase, achievement should lead to acquiring self-esteem and impulse control, and to learning to accept social conventions and respect legitimate authority.

If these various attributes are not achieved during this middle and late childhood period, a sense of "inferiority" may develop. This sense may inhibit efforts to learn new things and acquire new competencies. At the same time, there is likely to be low self-esteem, anxiety and maladjustment. In addition, the failure to develop self-control can lead to impulsive behaviour and instigating such behaviour in others. If "inferiority" rather than "industry" is the overall outcome of the last phase of childhood psychosocial development, the prognosis for adequate identity formation in adolescence is poorer.

While identity formation begins in infancy, it does not become a major psychosocial challenge until adolescence.[65] What is distinctive about adolescent psychosocial development is its intensity and its concentration on the particular challenge of establishing a coherent

self-identity. This whole developmental process may be characterized as one of "experimentation". In a gradual, hesitant process the adolescent takes on new viewpoints and tries out various behaviours. As time goes on, earlier opinions and ways of behaving may be rejected, modified in some respects or regarded as acceptable.

As parents and educators can attest, adolescent psychosocial development is not always a smooth and ordered process. When a person lacks a coherent outlook on life and a sound framework of thinking to address one's feelings, identity confusion occurs. As a passing and only partially manifested phenomenon, identity confusion is a normal part of development. When it persists and is not resolved, serious problems can arise.

In general there are three recognized stages of adolescent psychosocial development. While individuals may vary a bit in the age they enter or move from a particular stage, these stages are defined as follows: early phase (age 12-14), middle phase (age15-17) and late phase (age 18-22).

- Adolescence begins with an intense concern with developing a unique identity. In this early phase, this search involves moving away from the unquestioning dependence on parents for advice and values, and for meeting psychological needs (e.g., for self-esteem). Adolescents may no longer be willing to accept parental values and behaviours as standards for their own lives and parental advice may be rejected. Further, in this phase, adolescents may be self-assured that they can do no wrong and this assurance may lead to a lack of caution in behaviour.
- In mid-adolescence relations with parents tend to be more harmonious and there may be some willingness to consider or even accept parental advice or direction. This is not to suggest there is a total harmony with parents. The earlier movement toward autonomy continues and parental direction may be accepted only in part and on condition that it does not compromise efforts toward building personal identity.
- The late phase adolescent moves on to become a self-determining individual. In this final stage of identity formation, the individual freely chooses what will be incorporated into that self. This involves selecting what one wishes to include from the experience of the earlier stages of childhood identity formation, what parental guidance one considers as valid, and what values one wishes to adopt. At the end of this last phase of adolescent development, there is acceptance of oneself – the individual is comfortable with both the positive and negative aspects of her/his self-image.

Unfortunately some adolescents do not progress satisfactorily through the three successive phases of psychosocial development. These are the persons who are most at risk of substance use-related harm. For these high-risk individuals, identity confusion persists and has the following aspects:

- seeking instant gratification and not accepting that time and one's own effort could bring about a desired change;
- a constant questioning of self worth;
- persistent feelings of incompetence in performing tasks;
- inability to assume an appropriate role in social relationships;

- no commitment to a belief system (not necessarily religious) or a way of life.

All of these aspects of identity confusion can be risks for initiating and continuing substance use. Those who are obsessed with finding instant gratification can be enticed by the opportunity of feeling the immediate high produced by various drugs. Youth who are caught in a pathological questioning of self-worth can be prone to adopt deviant behaviour (e.g., drug use) out of a feeling that because they are worthless, it does not matter what they do.[66] Feelings of incompetence can heighten questioning of self-worth with the same outcome. Negative experience in social relationships at school (i.e., feeling isolated and not fitting in) poses a particular risk for dropping out and adopting the street lifestyle with its characteristic heavy use of alcohol and other drugs.[67] Youth with no commitment to a belief or values system are not constrained by moral or social behaviour principles.

This is not to suggest that substance use problems cannot arise in the context of "normal" adolescent development. Indeed, the normal incidents of impulsive, reckless behaviour in early adolescence, or a temporary state of identity confusion at any phase of psychosocial development, could be a time of vulnerability for substance use. However, those adolescents experiencing continuing identity confusion are at much greater risk for initiating and later experiencing substance use related harm.

Our knowledge about childhood and adolescent identity formation raises important considerations for substance use problem prevention programming. There is a need for well-designed universal programs in the early phase (age 12-14) of adolescent psychosocial development. These programs need to be timed to address the behaviours that can arise as a result of this intense period of identity development (e.g., a lack of caution in behaviour and the possible rejection of parental values and advice). It also suggests a need for multi-faceted selective programs that address a range of developmental concerns. Such programs need to be directed to at-risk groups that might consist of low achievers and those with low self-worth and poor impulse control at the "industry-inferiority" stage (i.e., middle to late childhood). These programs are needed in addition to, not instead of, the universal prevention programs that all children need to be exposed to at this stage. Selective programs are also needed for those high-risk youth who continue to show signs of identity confusion during adolescence. Finally, multi-faceted indicated programs with a harm reduction perspective are also needed for sub-sets of adolescents where risk factors linked to dysfunctional psychosocial development have already led to the onset and continuation of substance use.

Recognize youth perceptions of substance use

> **In order to be credible with participants, programs need to be aware of the way young people view the benefits and the risks associated with substance use.**

All substance use meets some type of perceived need on the part of the user. While some needs may be met through a drug's effect (e.g., relief of pain, feeling of pleasure), others may be met through symbolism associated with use of a substance (e.g., sense of rebellion, feeling of belonging).

Young people use substances for many of the same reasons as adults (e.g., stress relief); however, there are some perceived needs or benefits that are more pronounced with young people because they satisfy important needs related to adolescent development. These needs include: taking risks, demonstrating autonomy and independence, developing values distinct from parental and societal authority, signalling entry into a peer group, seeking novel and exciting experiences, and satisfying curiosity.[68]

A young person's perception of how common or "normative" substance use is can be an important influence on his or her own use of substances. For example, if there is a sense that most of their friends smoke, drink or use other substances, young people are more likely to do so. Some young people may use substances as consumer items such as clothes and music to establish an identity or image for themselves.[69] Some youth do not choose substance use *per se* but rather a lifestyle within which substance use is a part, along with other elements such as alienation, rebellion and seeking what they regard as freedom and friendship.[70]

Adolescent attitudes and beliefs regarding substance use and risk tend to change rapidly and become more tolerant with increasing age. More so than adults, youth tend to minimize the risks associated with their own substance use, with young men tending to do so to a greater extent than young women.[71] It has long been acknowledged that young people tend to give less attention to long-term risks associated with substance use than they do the more immediate consequences.[72]

Perceptions of risk by young people appear linked to rates of use.[73] This linkage has held in Canada over the past 10 years with attitudes of Canadian youth generally becoming more tolerant of substance use as rates have increased.[74] There is some indication that decreases in perceived risk associated with drug use precede and lead to increases in rates of use.[75] Attitudes of out-of-the-mainstream youth tend to be more tolerant still and are influenced by a need to escape negative emotions and experiences past and present, and in some cases, by simply not caring (i.e., suicide ideation).[76]

There is some indication that young people distinguish between lower-risk and more problematic use of substances. In one Canadian study of youth attitudes, those perceived to be using substances recreationally were considered popular socially, while daily or lone use was considered deviant and unacceptable.[77] This perception by young people is in line with research that suggests that young people who engage in occasional substance use tend to be better adjusted psychologically than either non-users or heavy users.[78]

While acknowledging the benefits of substance use perceived by young people, it is important that programs work interactively with participants to weigh perceived benefits against perceived risks in an unbiased manner. With higher-risk youth, this is best achieved through motivational counselling.

Involve Youth in Program Design and Implementation

> **Young people need to see themselves, and to be seen by others, as their own best resource for preventing and minimizing harmful effects associated with substance use.**

Those who plan or sponsor prevention efforts need to involve the young people in programming decisions on an ongoing basis. The most meaningful way to involve young people is through a community development approach that engages them in a process of identifying and working toward solutions to what they perceive to be their own issues. The process itself, regardless of the outcome, can be a powerful experience in building personal and group capacity for change.[79]

Participating youth who are involved in data gathering, program planning, modification and evaluation are less likely to drop out of the intervention, thereby increasing the possibility of it having the intended effect.[80] They are also more likely to be motivated to actively develop new skills and to be open to accepting new information. In some cases, this may mean having an opportunity to contribute to decisions on the process and pacing of the program. In other cases, it will make sense for the young people to assume primary responsibility for developing program messages and for implementing the program.

Peer-based approaches are being used with mainstream youth to address issues as wide-ranging as reducing impaired driving and promoting safer dancing at raves.[81,82,83] Marginalized young people (including those living in poverty, gay/lesbian persons and those with mental health problems) often have poor experiences with the service delivery system and are often poorly informed about available services and what they do. It is particularly important to engage and involve these young people in programming decisions in a respectful and non-judgmental way. Peers can be very helpful in an outreach capacity with out-of-the-mainstream youth.[84] A peer education approach has been used to modify risky behaviours among youth involved in injection drug use. Due to the illicit nature of their lifestyle, these youth are often hidden from the mainstream of health education. Compared to others, peer educators are more likely to reach youth involved in injection drug use, and to be viewed as credible advocates of health-promoting behaviour.[85,86]

Regardless of the sub-group, involving youth means nurturing trust and working cooperatively with and supporting credible representatives of the youth population as they clarify the problems; determine appropriate goals; and design, possibly deliver, and help to evaluate the prevention program or activity. It also means ensuring the supportive involvement of adults to facilitate and supervise program activities and to put youth in touch with other resources.

Creating an Effective Process

Develop Credible Messages

Both the explicit and implied messages delivered in a program need to be viewed as realistic and credible by participants, and need to be delivered by credible messengers.

Every program communicates a number of messages. Some are explicit (e.g., all drug use is unacceptable), while others are implied (e.g., a didactic approach communicates that youth participants may not have a worthwhile view). A good way to ensure appropriate message development is to involve youth participants in the design process. To illustrate: sponsors of a recent campaign in Florida that has achieved very positive short-term results attribute much of the effect to the fact that young people were involved with devising the message.[87]

The most important principle for every program, regardless of program goal, is that drug information be scientifically accurate, objective, non-biased and presented without value judgment. Regardless of the age of the intended target group, participants must be provided with accurate information and strategies for developing skills such as communication, decision-making, problem-solving and conflict resolution. Even if younger participants initially accept messages that focus solely on the negative aspects of drug use, once they receive more accurate information, there is a danger that all the messages received earlier will lose credibility.

It is important that programs discuss the reasons people use drugs and present alternatives to drug use. Information needs to address both the dangers and the benefits of using and not using drugs, and focus on short-term effects and consequences. Students will dismiss information that they perceive as contradictory to their own substance use experiences or the experiences of those around them (e.g., parents, older peers, famous individuals).

Fear-arousing messages accompanied by incorrect or exaggerated information are not effective, and can generate skepticism, disrespect and resistance toward any advice on substance use or other risk behaviour. These messages can actually erode motivation to deal with a problem, particularly when there are no accompanying coping strategies presented or if the consequences are presented as unavoidable.[88]

Similarly, simplistic messages that young people believe to be unrealistic (e.g., just say "no") or not feasible (e.g., play sports when there are no facilities readily available) will not be seen as credible. Because children and youth are less interested in distant, long-term effects, programs need to give greater attention to concrete "here and now" social consequences that can be avoided, such as being less attractive, smelling of tobacco and doing things that will be regretted afterwards.[89] Discussion of these consequences and risks, the benefits of not using, and alternatives to using substances needs to be presented in an accurate and unbiased manner.

As students increase in age, so typically does their drug use. As noted above, by Grade 11, the majority of students are using alcohol. Therefore, in addition to basic information about drug effects, it will be important to integrate new messages with respect to risky behaviours and safe use; for example: (a) identifying dangerous or unhealthy practices, such as driving or playing sports after using, chugging or bingeing, engaging in unplanned sex after using, studying or working after using, and using and sharing needles; (b) raising awareness level of regular and heavy users of the risk of dependence and long-term problems associated with these levels of use; and (c) increasing awareness of resources available for those motivated to reduce or quit use and supporting access to services.

Inclusion of these types of messages can support a harm reduction program goal; that is, not focusing on eliminating alcohol and other drug use, but rather on minimizing the negative impact of drug use for the user, the community and the society. Adopting a harm reduction approach requires: providing factual information; providing resources; teaching skills and strategies; and building on existing capacities, strengths and practices of participants.

While most relevant in developing media messages, it is useful for prevention program developers to pay attention to the norms, values and language of young people and youth culture.[90] Some of the dominant concerns of young Canadians include getting ahead in a competitive economic environment, managing relationships, fitting in, and certain health issues such as attractiveness and managing stress.[91] Youth today are generally optimistic, self-reliant and in search of authenticity. Many are also idealistic, activist and have a strong sense of social justice. Fashion and language change rapidly, but there are core features to youth culture, such as rapid change, non-linear thinking, low respect for prescribed authority and for second-hand adult attempts to be "cool".[92] Messages that connect substance use with these issues, aspirations and values are more likely to be attended to.

For instance, a study of youth involved with injection drug use found that while the social norm was to generally not share needles, sharing with friends or sexual partners was considered acceptable.[93] [94] Trust was seen as an important part of close relationships, with needle sharing a way of demonstrating that trust. As such, campaigns carrying the message that one should never share needles may have limited impact. It is important that prevention initiatives address the values and beliefs underlying the target behaviour.

It is important to bear in mind that youth are not a homogeneous population and that there are a number of youth subgroups or cultures with their own distinct norms and values (e.g., ecstasy use at raves and non-violence among "ravers"). Gender also needs to be considered in preparing appropriate messages for substance use problem prevention. For example, provocative messages that trigger strong affective responses and interpersonal discussions have been found to be effective with young girls. Boys, who are at greater risk of substance use, will likely be influenced more by themes relating to action, competition, bodily sensations and peer group membership.[95]

Youth who seek novel and exciting experiences tend to be more likely to engage in substance use.[96] So, messages that acknowledge curiosity and the appeal of risk-taking while offering reasonable alternatives to achieve it may be effective with these adolescents. It is crucial that ethno-cultural beliefs of participating youth be understood when developing program messages. For example, messages that integrate with traditional teachings and practices appear most promising with prevention programs for Aboriginal youth.[97,98]

Combine Knowledge and Skill Development

> **Skill development needs to be a central element in programs and it needs to be accompanied by accurate, objective information.**

Programs that focus on knowledge only do not bring about change in adolescent substance use behaviours. Affective education approaches focusing on such issues as self-esteem and personal values and beliefs without making specific reference to drugs have been shown to be ineffective when used alone or in combination with a knowledge component.[99,100]

Some school programs include components that aim to develop specific resistance skills. However, heavy reliance on resistance training is less likely to be effective, given that "peer pressure" has been exaggerated as a causal factor in risk behaviours.[101] Considerable evidence suggests that associating with drug-using peers is often a consequence rather than a cause of substance use.[102] That is, young people thinking of using seek out a drug-using group, and while they may not have been pressured into using by peers, they may be pressured not to quit.[103]

A broader life skills approach may render better results than a narrower focus on refusal or social resistance skills.[104] Based on social learning theory, the types of skills covered in a broad life skills program include decision-making, goal setting, stress management, assertiveness, and communication skills and are intended to generalize to various situations and health-related behaviours. Mastery of these skills can enhance the young person's self-confidence in dealing with these situations. Requiring an interactive process, life skills sessions usually include demonstration of the skill, practice and feedback on the use of the skill, discussion on applying it and ongoing modelling of the skill.[105]

Another type of program challenges common or normative assumptions about the acceptance of substance use in society. The "normative" approach is based on the contention that beliefs of what is normal or accepted are important factors in youthful substance use, in that if a young person believes that most people are using substances, they will perceive less risk and are less likely to abstain from use or be worried about use. These programs seek to undermine popular beliefs that "everyone else" is doing drugs. Student surveys and opinion polls can be used to give students an understanding of actual rates of use and aid them in setting their own norms. The normative approach may make more sense with older students, as life skills appear to be more difficult to affect at this point.

This is not to say there shouldn't be a knowledge component to a prevention program. In all of these various approaches, acknowledgement of the perceived benefits along with information on possible health and social consequences of drug use presented in a factual, balanced fashion can clarify personal risk and support decision-making.[106] As much as possible, it is important that the knowledge component focus on practical rather than theoretical knowledge.[107] For example, street youth are relatively knowledgeable of the health risks associated with the use of various substances and are unlikely to pay attention to information on the negative consequences of drug use.[108] However, they may be receptive to a practical, harm reduction message (e.g., try a little first to see how it feels, rather than a regular dose; or where to find help, or how to provide help to others). Participants can often develop this information from their own experiences. In conjunction with the provision of information, preventive strategies directed to street youth need to address the psychosocial factors associated with their use of substances, including a need to escape painful emotions and experiences, depression, low self-esteem, and peer relations.

Use Interactive Group Process

> **Engage and involve participants in skill development activities and discussions.**

Complementing the psychosocial content, prevention programs that show greatest effect use an interactive group process (interaction in this case means peer to peer, rather than between instructor and youth).[109] Interaction appears to be critical in obtaining behavioural goals (non-interactive approaches appear capable of affecting knowledge only). Interactive programs employ role-plays, Socratic questioning, simulations, service-learning projects, brainstorming, cooperative learning and peer-to-peer discussion to promote active participation among youth. These types of "hands-on" activities provide valuable opportunities for youth to clarify their beliefs and to practice helpful skills, such as problem solving, decision-making, and communicating effectively.

Best conducted in small groups, this approach calls on the leader to oversee the activities, establish a supportive environment, keep groups on track and ensure that each adolescent has an opportunity to participate and receive feedback on their use of these skills. For older adolescents, a less structured interactive approach may be most appropriate, with the same aim of encouraging the participation of the full group or class within a supportive atmosphere. The role of the teacher or leader with these approaches is to facilitate and to assume a directive role only when it is necessary to correct a misconception.[110] Interactive programs appear to be effective across drug type (i.e., alcohol, tobacco, marijuana, and other illicit drugs), and across ethnicity.[111]

Give Attention to Teacher or Leader Qualities and Training

> **Select and train leaders or teachers who demonstrate competence, empathy and an ability to promote the involvement of young people.**

Program messages are more likely to be attended to if the leader or teacher is accepted and respected by the target group. Acceptance is more likely if the leader is comfortable with the program's content and process. Most effective prevention programs require teachers or leaders who are comfortable in a facilitative rather than directive role. Even programs that have been shown to be effective will be seriously hampered by teachers or leaders who are unable to deliver the programs as they were designed to be delivered.[112] Mental health professionals have been shown to be effective in this capacity, particularly with high school students.[113] Teachers who have been trained for these types of programs can be effective and have the advantage of being available on a daily basis. Training needs to offer demonstration of interactive teaching techniques and ample opportunity to practice these skills.[114] Teachers may be more effective with younger students than with high school students. Young people can serve as leaders or as co-partners with an adult, by, for example, helping to create an appropriate environment and initiating discussion.[115,116] What appears to matter most is that the teacher or leader

demonstrates competence, empathy and an ability to promote the involvement of young participants. Training is often helpful in developing these attributes and ensuring that programs are conducted as they were designed to be delivered.[117] Peer approaches may be particularly useful in working with out-of-the-mainstream youth.[118]

Conclusion

Too many prevention programs for youth in current use are not supported by scientific evidence. At the same time, there are an increasing number of programs that are showing evidence of effectiveness but are not widely used. Even though the size effect found in current evaluated programs is often quite small, there is now a clearer understanding of the most important ingredients of youth substance use problem prevention, and they are embodied in these prevention principles. Regardless of whether sponsors adopt an existing program "off the shelf" or develop their own program, it makes sense to refer to these principles to ensure a sound program direction. One route would be to select the program exemplar that best reflects the principles sponsors wish to emphasize and use the exemplar for ideas for a framework to operationalize these principles.

More emphasis is needed on disseminating these principles, and on ensuring that local communities, program planners and developers have ready access to research-based knowledge and tools to develop and implement effective programs. Improved national and local data, both quantitative and qualitative, is fundamental to evidence-based program development. In any given community, planners need to pay attention to the big picture, by planning and implementing comprehensive programs and strategies. Universal programs, including strong supportive policies, are needed to reach a broad population base and "till the soil" for more targeted programs; selective programs are needed for youth and families "at risk", while more intensive programming and services must be available for those who are experiencing more serious problems.

More program evaluation needs to be financially supported and conducted with Canadian programs that attempt to put the principles into action. Evaluation that explores which components or principles are more significant than others, would be very useful in developing more cost-effective programming in the future. Program developers and deliverers should monitor costs of implementation more closely as well, to ensure that program benefits outweigh the costs and that program expenses do not prohibit effective programs from being replicated. When initiating a program, sponsors and funding bodies need to give concerted attention to ensuring sufficient resources to work with over the short and long term.

Through the development and wide dissemination of this compendium, we hope that we will be able to increase the capacity of communities throughout Canada to plan and implement evidence-based programs that will serve to prevent and/or reduce problems associated with substance use among our youth. By combining research-based knowledge and tools with community commitment and energy, we believe we can make a difference.

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116. **Perry, C.L., Grant, M.**, Comparing Peer-Led and Teacher-Led Youth Alcohol Education in Four Countries. *Alcohol Health and Research World*, Vol. 12, 322-326, 1988.

117. **Drug Strategies**, Making the Grade: A Guide to School Drug Prevention Programs, Washington DC: Drug Strategies, 1997.

118. **Breland, K., Tupker, E., West, P.**, Let 'Em Go – The Street Involved Youth Harm Reduction Project Experience. Toronto: Centre for Addiction and Mental Health, 1998.

Section 4

Exemplary Programs from the Scientific Literature

This section describes and analyzes 33 programs with a range of aims, target groups and settings that have been shown to be effective through rigorous evaluation. Among the programs presented are eight that focus on the unique needs of injection drug using youth. Programs in this section were identified by:

- defining a minimum standard for inclusion into the candidate pool, which was a quasi-experimental design reporting positive effect on substance use measures in a peer reviewed journal;
- developing a matrix that categorized programs according to target group (universal, selective or indicated) and setting (school, family/parent, community, combined, street);
- reviewing nine credible reviews of effective programs and compiling a list of programs that met inclusion criteria;
- identifying poorly represented areas of the matrix: high risk/street/IDU youth, DWI programs, parent/family programs;
- conductimg a second, targeted search of the literature to fill in gaps and to capture any program evaluations reported in the scientific literature since the most recent reviews, (i.e., 1998 to 2000). Databases searched: CANBASE, CCSADOCS, CEI, ERIC, Medline, ETOH, NCADI and the French-language databases of the Centre québécois de documentation en toxicomanie, and the National Documentation Centre in Lyon, France;
- developing a coding form to rate each study on quality of research design and study outcomes;
- checking the reliability among three raters;
- rating 115 articles and selecting 33 programs that ranked highest in overall quality of research design and outcomes;
- describing the 33 programs based on information contained in research articles;
- sending a description to principal authors of research articles for confirmation of information;
- entering new information from authors and publishers.

Headings have been omitted in cases where no information pertaining to the heading was obtained. Program costs are in the currency of the author's country. In some cases, authors provided additional studies pertaining to the described program. Generally, complete bibliographic information was not received, yet there is sufficient information to obtain the article from the author or publisher.

All Stars

(Based on the strategies of AAPT- the Adolescent Alcohol Prevention Trial)

Target Population:

Universal; 6th or 7th Grade students with one-year boosters and a preparatory program for 4th and 5th Grades.

Setting:

School-based and community-based versions.

Theoretic Basis:

Cognitive – behavioural.

Program Description:

Focus

Alcohol, tobacco, and marijuana.

Goals

The program that is commercially available has five goals: 1) establish conventional norms and correct erroneous normative beliefs, 2) build psychological dissonance between substance use and desired lifestyles, 3) establish voluntary commitments to avoid substance use, 4) promote bonding with prosocial institutions, and 5) promote positive parental attentiveness.

Objectives

To test the effectiveness of two methods: normative education versus no normative education and resistance training verses no resistance training on substance abuse use.

Activities

Students learn about true prevalence rates and underlying conventional attitudes through playing games, participating in activities that visually demonstrate students' opinions, participating in structured debates, and by making public commitments about intended future behaviours. There is a combination of interactive and didactic techniques (e.g., films, presentations, homework assignments, surveys, interviews, role-playing, discussions, video tapes, question boxes).

Content

The researched program included 4 - 45 minute "Information" lessons about the social and health consequences of using alcohol and other drugs and 5 lessons of "normative education" that corrected erroneous perceptions of the prevalence and acceptability of alcohol and drug use among peers and established a conservative normative school climate regarding substance use.

Contact Time:

As above plus one-year booster.

Leader Type and Training Provided:

Programs were delivered by program staff; each program specialist received a minimum of 2 weeks of intensive training.

Intended Outcomes:

The goal of the research was to compare the effectiveness of a program that teaches resistance skills and one that reinforces conservative norms; to test the effectiveness of two methods, normative education versus no normative education and resistance training verses no resistance training on substance use. The normative education program designed to correct erroneous perceptions among students about the prevalence and acceptability of these substances significantly deterred the onset of use.

The resistance training program that teaches students ways to resist offers to use substances had no discernable positive impact on use behaviour.

For all three substances, those who received a version of Normative Education as opposed to no normative education, had significantly reduced rates of consumption. For alcohol the strongest effect of normative education was in delaying the onset of ever being drunk.

Adding sex, ethnic and family income as covariates did not change the pattern of results for alcohol and tobacco. However, family income was the only significant covariate for alcohol, tobacco and marijuana. However, including this covariate in analyses actually strengthened the effect of normative education and had no effect on resistance training.

Although the samples were not equivalent across ethnic groups, ethnicity was not a significant covariate nor did it alter the main drug use findings.

The combined program was clearly superior in preventing the prevalence of monthly marijuana use. Resistance training only may have had a slightly harmful effect.

Author's Comments:

- this program was equal to other resistance training programs in content and was well delivered;
- the self-report data reflect reasonably valid responses by subjects;
- speculate that the primary causes of alcohol and drug use have to do with the social availability of and internal expectations about the social acceptability of use of these substances;
- a possible explanation for the failure of the resistance training program in terms of marijuana use is that focusing solely on techniques to resist pressure may actually increase students' perception of prevalence;
- speculate that the success of the resistance training in other trials could be due to norm restructuring even when other mediating processes are thought to operate.

Reviewer's Comments:

Found this study to be a very interesting counterpoint to the studies supporting "resistance skills training". Principles emphasized: there is a focus on covering a number of risk and protective factors; emphasis on the "real" information on prevalence of using various substances; active and creative activities requiring student participation; no booster sessions were incorporated; an intensive 2-week training program for leaders; key programs delivered over a reasonable number of weeks (in comparison to other programs).

Year Program Established:

1987-88 school year.

Associated Studies:

Hansen, Graham, Preventing Alcohol, Marijuana, and Cigarette Use Among Adolescents: Peer Pressure Resistance Training versus Establishing Conservative Norms (1991).

Donaldson SI, Graham JW, Hansen WB. Testing the generalizability of intervening mechanism theories: Understanding the effects of adolescent drug use prevention interventions. Journal of Behavioural Medicine 1994; 17(2): 195-216.

Donaldson SI, Graham JW, Piccinin AM, Hansen WB. Resistance skills training and onset of alcohol use: Evidence for beneficial and potentially harmful effects in public schools and in private Catholic schools. Health Psychology 1995; 14: 291-300.

Hansen WB, Graham JW, Wolkenstein BH, Rohrbach LA. Program integrity as a moderator of prevention program effectiveness: Results for fifth Grade students in the Adolescent Alcohol Prevention Trial. Journal of Studies on Alcohol 1991; 52(6): 568-79.

Hansen WB. Pilot Test Results Comparing the All Stars Program with Seventh Grade D.A.R.E.: Program Integrity and Mediating Variable Analysis. Substance Use & Misuse. 1996; 31(10): 1359-1377.

Harrington NG, Giles SM, Hoyle RH, Feeney GJ, Yungbluth SC. Evaluation of the All Stars Character Education and Problem Behaviour Prevention Program: Pretest-Post-test Effects on Mediator and Outcome Variables for Middle School Students. Health Education Research. In Press.

Program Sponsors:

Staff:

Dept. of Public Health Sciences
Bowman Gray School of Medicine
Wake Forest University
Winston-Salem, North Carolina

Department of Preventive Medicine
School of Medicine
University of Southern California

Financial:

Supported by a grant from the National Institute on Alcohol Abuse and Alcoholism

Contact:

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Tanglewood Research, Inc.
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336-662-0090

Alcohol Misuse Prevention Study (AMPS)

Target Population:

Universal; Grades 6 through 8, sequentially.

Setting:

School.

Theoretic Basis:

Social learning theory.

Program Description:

Focus

The focus of this program is specifically to inoculate students against the pressures of alcohol use and misuse and to reduce their increasing rate of alcohol misuse.

Objectives

The objectives of the program are: to teach students about alcohol use and misuse in their social contexts; to develop students' skills in identifying and resisting social pressure to use and misuse alcohol; and to foster positive peer support for resisting alcohol.

Activities

The activities involve the students and combine a number of teaching techniques such as: information giving, positive reinforcement, use of audio-visuals, student activity sheets, handout materials, and the development of refusal skills and practice. The program leaders strive to refute common expectations for alcohol use, to set appropriate norms, and to teach students skills in decision making and problem solving.

Contact Time:

8 – 45 minute sessions on consecutive days in Grade 6;
5 – 45 minute sessions on consecutive days in Grade 7;
4 – 45 minute sessions on consecutive days in Grade 8.

Leader Type and Training Provided:

Teachers had various training periods with weekly meetings to ensure standardization of curriculum:

Grade 6 = 38 hours;
Grade 7 = 28.5 hours;
Grade 8 = 21.5 hours.

Intended Outcomes:

The rates of alcohol use increased significantly for all subgroups and were not significantly affected by the curriculum. However, the group who had previous unsupervised alcohol use showed significantly less increase than the control group. The study group also had higher curriculum knowledge than the controls.

The curriculum had a detectable difference despite pretest differences, differential attrition and lower levels of drinking. This supports the benefit of the program for students with prior unsupervised alcohol use.

Program Costs:

Not estimated, but minimal for materials, training flexible.

Author's Comments:

Attrition effects may have diminished the results: i.e., the loss of more control than curriculum students; the loss of more boys than girls; the loss of more unsupervised drinkers; the loss of heavier drinkers. Further details are available from the first or second authors.

Reviewer's Comments:

An attempt was made to standardize and monitor the implementation of the curriculum by weekly meetings, teachers' self-rated performance, staff rating of teachers several times based on defined criteria, which included a rating of student involvement and responsiveness. Exposure to the curriculum was strictly school-based and included minimal activities for parents, and none for the community as a whole.

In terms of preventive principles reflected, the strength of this version of the AMPS program lies in life skill development in the form of skills training, problem-solving and decision-making skills and the inclusion of normative training around the use and prevalence of alcohol use and misuse.

Attention was paid to the leadership quality and the standardization of the implementation of the program, a factor that is not always acknowledged but has an impact on the results when evaluating the effectiveness of a program.

Although the intensity and duration in each year were not substantial, the fact that it was implemented in 3 consecutive years is important. In addition the program was not done on a weekly basis but on consecutive days, as preferred by the schools.

Year Program Established:

1989.

Associated Studies:

Shope, Kloska, Dielman, Maharg, Longitudinal Evaluation of an Enhanced Alcohol Misuse Prevention Study (AMPS) Curriculum for Grades Six-Eight (1994) Journal of School Health 64(4), 160-166.

Program Sponsors:

Staff:

University of Michigan faculty and staff.

Funding:

Grant from the National Institute on Alcohol Abuse and Alcoholism.

Contact:

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Illawarra Program

Target Population:

Universal.

Setting:

School; conducted over 4 years from Grade 6 to Grade 10.

Theoretic Basis:

Social learning theory; social inoculation theory; problem behaviour theory; developmental considerations.

Program Description:

Focus

The focus is on pre-adolescent children and legal substances that are the "gateway substances" (i.e., tobacco, alcohol, over-the-counter medications and prescriptions).

Goal

"The goal of the Illawarra Program is to curb adolescent drug use and help young people make decisions regarding drug use that will be health promoting rather than injurious to health." The program concentrates on peers and parents over a substantial period of time.

The Program Consisted of a Number of Parts

In *Part One*, six teaching units are spread out over a number of weeks, the topics covered included: information on drug use and misuse, decision-making strategies, identifying social pressures, developing resistance and assertiveness skills, decision-making strategies and issues of conformity.

Part Two involves having the students apply what they have learned in groups by creating artwork, posters, and paintings as well as developing plays, skits and videos. Parents who had received two previous education sessions attend a presentation of the students' work in part two. This second stage also creates a public commitment procedure in the joint parent and peer presentation session where young people indicate their decision to avoid the use of harmful substances.

In *Part Three*, the students who have participated in the program graduate into high school where approximately 2 months into the new academic year they show their work to students from other feeder schools who have also entered high school. Then 9 – 12 months later they return to their old school to introduce the program to the Grade 6 students who are just starting the process.

In subsequent redevelopments of the program, students continue to make more video and artwork or newspaper responses as they move through the Grades toward Grade 10. Grade 10 materials are then shown to Grade 8 students so that the program extends through several years.

Contact Time:

- Six initial sessions in part one (12 – 16 hours);
- Application activities in part two (12-16 hours);
- Three parent education nights, the last of which was the presentation of the students' work;
- In high school, students share their work with other students from different primary feeder schools;
- High school students return to their primary class and introduce the program to their peers.

Leader Type and Training Provided:

Leaders were the elementary class teachers under the direction of the program developers. Training was provided through a 50-page manual and by watching videos made by previous groups that showed their final product viewed at the parent presentation night. Training took 2 school days and the costs for the manual was $50 per participating school.

Intended Outcomes:

The study outcome expectations as a result of the program were behaviour patterns that reflected a more moderate, limited and responsible approach to drug taking in terms of:

- a reduced incidence of frequency of drug use behaviour for all legal gateway drugs;
- a reduced level or intensity of drug use and of subsequent derived effects from the use of gateway drugs;
- a demonstrated ability to resist peer group pressure to use alcohol, tobacco and other drugs;
- a responsible, limited and minimal use of legal drugs and attitudes opposing harmful drug use, leading ultimately to a positive effect on the progression to illegal drugs.

Actual outcomes:

- initiation to alcohol use showed no differences although levels of drinking varied across all years;
- the study groups adopted lower levels of initiation into drug use and lower intensity and frequency of use as compared to controls;
- in Grades 7 and 8 the study group showed a significantly better ability to resist pressure to use drugs but this faded in Grades 9 and 10;
- the program influenced experimental group subjects to use fewer drugs and to use some drugs in a more responsible or reduced way.

Program Costs:

The cost for one year was set at the release of teachers for 2 school days per year plus less than $3,000 for video hire per school district.

Author's Comments:

Grade 9 appears to be a critical year when greater experimentation may occur, and therefore may be an appropriate time to add a booster session; early education can have an enduring effect but booster sessions are important to reinforce information and commitment; initiation into alcohol and analgesic use shows no appreciable differences when drugs are widely accepted and have been tried by students prior to the education course; drugs occurring later in the progression such as tobacco and marijuana do show different patterns of initiation; peer-based strategies including behaviour rehearsal and social commitment seem to work.

The author felt that the program emphasized the following principles most particularly: address protective and risk factors; address program sustainability from the beginning; and involve youth in program design and implementation.

Reviewer's Comments:

This program had many aspects that are considered best practice. It had very clear expectations related to outcomes that facilitated the evaluation. It took the best components and theory base of other programs that had an impact and put them together. Contact was intense and frequent, including booster sessions that reinforced the material in different ways and forms. Youth were involved and active in reinforcing their learning as well as presenting the information to younger students.

The program combined life skills in the form of resistance training and decision making as well as basic information. It addressed risk and protective factors and included parent education as part of the package. The presentation of material by students to their parents also opened up the lines of communication between parents and their children on the topic of drugs.

The program was tailored to the study population in that it focused on the age and stage of the students and the progressions of drug involvement for this age group. It concentrated on legal drugs that can be easily obtained by this young age group rather than the more exotic drugs like cocaine.

Year Program Established:

1983–84.

Associated Studies:

"The Longitudinal Evaluation of a Primary School Drug Education Program: Did it Work?" (1990) Wragg. J.

Program Sponsors:

Staffing:

University of Wollongong, New South Wales.

Funding:

Research into Drug Abuse from the Commonwealth Department of Community Services and Health for the Evaluation. The project was funded by school districts and incorporated into their curriculum and costs were for release of teachers for training only and then for hire of video equipment.

Contact:

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Life Skills Training Program

Target Population:

Universal; research targets were white middle-class Grade 7 public school students in 56 schools in various areas of New York State. Minority sample (26% African-American and 70% Hispanic) of low-income Grade 7 public school students in 7 urban schools in New York City.

Setting:

School; research settings were public schools in various places in the state of New York.

Theoretic Basis:

Cognitive-behavioural prevention approach; Problem behaviour theory; Social learning theory.

Program Description:

Focus

To teach students to develop personal self-management skills, general social skills and drug resistance skills regarding tobacco, alcohol, marijuana and other illicit drugs.

Goals

- Provide adolescents with the requisite knowledge and skills for resisting social influences to use alcohol and drugs as well as reduce potential motivations to use alcohol and drugs by increasing general personal competence;
- Alter norms concerning the prevalence and acceptability of drug use;
- Teach skills for resisting social influences promoting drug use.

Objectives

Teach students cognitive-behavioural skills for building self-esteem, resisting advertising pressure, managing anxiety, communicating effectively, developing personal relationships and asserting rights.

Activities

Combination of techniques including demonstration, behavioural rehearsal, feedback and reinforcement and behavioural "homework" assignments for out-of-class practice.

Content

Each unit consists of a major goal for the unit, measurable student objectives, content and classroom activities.

- Skills for the enhancement of generic personal and social competence;
- Problem specific skills and knowledge related to smoking, drinking and drug use;
- Application of general assertiveness skills in situations of pressure;
- Immediate negative consequences;
- Decreasing social acceptability of use;

- Actual prevalence rates;
- Only minimal information regarding the long-term health consequences of use.

* A description of the preventive strategy and the curriculum materials can be found in Botvin & Dusenbury, 1987; Botvin & Tortu, 1988.

Contact Time:

- 12 units taught in 15 class periods in Grade 7 (plus 3 optional violence units);
- Booster sessions in Grade 8 (10 class units);
- Booster sessions in Grade 9 (5 class units).

Leader Type and Training Provided:

Regular, selected classroom teachers were provided with a 1-day training workshop to explain the rationale for this preventive approach and describe the curriculum materials and do a session by session overview of the curriculum. They were observed and received a 15-minute session to provide feedback on their implementation.

In the multimodal study, the second implementation group of teachers was provided with a 2-hour training video, written instructions and the curriculum. These results were comparable to the group that received the 1-day training program.

Peer leaders were generally used in an ancillary way and not as primary program providers. Peer leaders were selected by the school system and given a weekend workshop that provided an overview of the curriculum. They also had bi-weekly practice sessions to practice the role-plays during the semester.

Intended Outcomes:

Drug abuse prevention programs conducted during junior high school can produce meaningful and durable reductions in tobacco and marijuana use, if they are properly implemented, teach a combination of social resistance skills and general life skills and include at least 2 years of booster sessions as evidenced by a 6- year follow-up study.

No significant effects were found for drinking frequency or amount, however, the frequency of getting drunk was significantly less in the videotape teacher training condition.

The booster conditions were superior to the non–booster conditions. The peer-led booster condition was the most effective and the only one to produce significant and substantial behavioural results.

The effectiveness of the program is related to the level of implementation.

Program Costs:

The LST Provider Training Workshop is designated to prepare providers to deliver curriculum with content and process fidelity. Using a Certified LST trainer to conduct provider training workshops is one of the ways to ensure program fidelity and effectiveness. National Health

Promotion Associates, Inc. (NHPA) has certified over 40 trainers throughout the US to ensure research-based implementation fidelity of LST. Dr. Botvin has a publishing agreement with Princeton Health Press Inc., which has agreed to publish the prevention curriculum used in this study.

Direct LST Costs $US (program materials and staff training)

Curriculum Teachers Manual, 30 Student Guides, Relaxation Tape

- Year 1: Core (6th/7th Grade) $275;Year 2: Booster (7th/8th Grade) $225;
- Year 2: Booster (7th/8th Grade) $225;
- Year 3: Booster (8th/9th Grade) $175;
- Full Set (Years 1,2,3) $625.

Additional Student Guides (in packs of 10):

- Year 1: Core (6th/7th Grade) $60;
- Year 2: Booster (7th/8th Grade) $50;
- Year 3: Booster (8th/9th Grade) $40;
- Additional Relaxation Tapes $10;
- Single Teachers/Student Guide $100.

Training Costs:

$200 per participant for 2-day training (a minimum of 20 participants and teacher /student guide per participant required); certified trainer travel expenses (travel, lodging per diem); training sponsor is responsible for costs associated with the training site, equipment rental and promotion.

Author's Comments:

Many teachers did not implement the skills training portion of the curriculum. There could be a number of reasons for this (e.g., not comfortable with this approach or not convinced that this approach was effective). The project team did not participate in the selection of the teachers nor establish selection criteria. Provider attitudes that are too moralistic or too permissive might have the potential for undermining even the most effective prevention program and produce undesired effects. The program has high exportability, and can be packaged for large-scale dissemination and utilization.

Reviewer's Comments:

It is necessary to have enthusiastic, confident and adequately trained program providers. It is important to develop quality control procedures to insure a high degree of implementation fidelity. This program has undergone extensive study, including conditions and factors that might have an effect on the efficacy of the program (e.g., teacher training and type of training including peer led components have been studied). Goals are clear and the program attends to a

number of risk and protective factors related to an individual's ability to resist influencing factors in their environment. Active participation is required for a number of activities for which the development of life skills is a focus. The programs are of a substantial length and include booster sessions for 2 years following the initial program.

Year Program Established:

1983 – program developed;
1983 – 3-year study begins;
1984 – 1-year follow-up;
1985-1991- 6-year randomized trial long-term follow-up.

Associated Studies:

A Cognitive-Behavioural Approach to Substance Abuse Prevention: One Year Follow-up. (1990); Botvin, Baker, Filazzola, Botvin.

Preventing Adolescent Drug Abuse Through A Multimodal Cognitive-Behavioural Approach: Results of a 3-Year Study. (1990); Botvin, Baker, Dusenbury, Tortu, Botvin.

Long- term Follow-up Results of a Randomized Drug Abuse Prevention Trial in a White Middle-class Population. (1995);Botpvin, Baker, Dusenbury, Botvin, Diaz.

School-Based Drug Abuse Prevention with Inner-City Minority Youth. (1997); Botvin, Epstein, Baker, Diaz, Ilfill-Williams.

Preventing illicit drug use in adolescents: Long-term follow-up data from a randomized control trial of a school population. (2000); Botvin, Griffin, Diaz, Scheier, Williams, & Epstein.

Program Sponsors:

Staff:

Institute for Prevention Research, Cornell University Medical College.

Financial:

Grants from the National Institute on Drug Abuse;
Grants from the National Cancer Institute;
Grants from the National Heart and Blood Institute and the New York State Division of Substance Abuse Services;
Grant from the Office of Juvenile Justice and Delinquency Prevention;
Contract from CSAP's (Center for Substance Abuse Prevention) National Center for the Advancement of Prevention.

Contact:

To order LST materials, contact:
Princeton Health Press, Inc.
115 Wall Street
Princeton, NJ 08540
(800) 636-3415; fax (609) 921-3593
E-mail: PHPinfo@aol.com

To receive information on LST provider training, contact:

National Health Promotion Associates, Inc. (NHPA)
Training Department
141 South Central Avenue, Suite 208
Hartsdale, NY 10530
(800) 293-4969; fax: (914) 683-6998
E-mail: training@nhpanet.com

To learn more about specific prevention research projects, contact:

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Project ALERT

Target Population

Middle school students (original research targetted entire Grade 7 cohort of 30 junior high schools).

Setting:

School settings from 8 urban, sub-rural and rural communities in California and Oregon.

Theoretical Basis:

- social influence model;
- self-efficacy theory of behaviour change;
- health belief model.

Program Description:

Focus

Tobacco, marijuana, alcohol use.
Four cognitive domains:

- Perceived consequences;
- Normative beliefs;
- Resistance self-efficacy;
- Expectations of future use.

Goals

Curb adolescent drug use by motivating young people to resist drugs and helping them acquire the skills to do so.

Objectives

Help students understand how drugs can affect them and build resistance motivation (health belief model) by:

- recognizing the bad personal consequences associated with taking drugs (e.g., losing control, "ashtray breath");
- understanding that they themselves are personally susceptible to those consequences (bad things can happen now and affect daily life and social relationships);
- counteracting the normative belief that "most kids use drugs";
- recognizing the benefits of non-use.

Help students identify pro-drug pressures and acquire a repertoire of strategies for resisting those pressures by:

- realizing that they can avoid those costs through successful resistance (delete: by identifying internal and external pressures);
- identifying and countering advertising appeals;
- identifying and countering both internal and external pressures to use;
- practicing different resistance strategies.

Activities/Process

- Participatory style: consisting of question and answer techniques, small group exercises, role modeling, repeated skills practice;
- Modeling: students hear and see how older teens and classroom peers have resisted;
- Performance accomplishments: use role-playing, psychodrama, and written responses to practice different ways of saying "no";
- Verbal persuasion: receive reinforcement for successful performance;
- Small group discussions: question and answer exercises – foster participation and allow teachers to adjust program content to diverse classrooms with different levels of information and exposure to drugs.

Content

Help students:

- understand the consequences of using drugs;
- develop reasons not to use drugs;
- identify pressures to use them;
- establish school-wide norms against use;
- understand the benefits of being drug-free;
- recognize that most people do not use drugs;
- identify and counter pro-drug messages;
- resist advertising appeals;
- resist social and internal pressures to use;
- support others in making non-use decisions;
- recognize alternatives to substance use;
- nderstand the benefits of quitting;
- promote parent involvement through home learning opportunities.

Contact Time:

- 11 lessons a week apart;
- 3 boosters the following year.

Leader Type and Training Provided:

Research trial:

- 10 schools had adult health educators;
- 10 schools had older teen leaders from local high schools assist the teachers;
- their role was to provide personal examples of effective resistance and to help students believe that they too could successfully resist drugs.

Currently available:

- 1-day training workshop;
- toll-free teacher assistance phone line.

Intended Outcomes:

- equally successful in schools with high and low minority enrollment;
- positive results were realized for both low- and high-risk students for tobacco;
- very effective with high-risk tobacco experimenters;
- did not help committed smokers, increasing smoking for this group in teen leader schools;
- effects on alcohol use were short lived;
- curbed initiation of marijuana use for non users by one third;
- reduced current use of marijuana by over 50%;
- teen leader schools showed stronger effects on cognitive risk factors at Grades 9, 10 and 12;
- when adults taught the lessons without teens, fewer beneficial effects on beliefs persisted in high school;
- all the earlier effects on actual use disappeared by Grade 9 regardless of who taught the lessons.

Program Costs:

Resources included with one-day training workshop ($125 per teacher):

- Manual with 11 lessons for year one and 3 booster lessons;
- Eight interactive student videos;
- Twelve classroom posters;
- Overview video;
- Free newsletter, 3 times a year;
- Toll-free teacher assistance phone line.

Author's Comments:

Proposed reasons for the erosion of the positive effect by Grade 9:

- resistance skills and motivation to use them may decay without continued reinforcement;
- loss of impact on expectations to use drugs may have severed an essential link between other beliefs about drugs and subsequent behaviour;
- increased pressures confronting adolescents in high school may overwhelm earlier resistance learning – both cognitive and behavioural.

Reviewer's Comments:

Use of older teen leaders increases and prolongs the effect of the intervention in some cases. Continued reinforcement (booster lessons) are required to sustain preventive gains through high school.

With respect to prevention principles emphasized: use of older teen leaders to provide assistance to the teachers of the program; use of a combination of techniques to address the goals of the program; focus on life skills development; interactive format for covering the topics; regular updating of materials; provision of training and technical assistance.

Program Sponsors:

- Rand Corporation (program development and research)
- The Best Foundation (training and dissemination)
- Grant from the Conrad N. Hilton Foundation (for research and dissemination)

Year Program Established:

1984 – 1986.

Associated Studies:

Drug prevention in junior high: a multi-site longitudinal test. (1990); Ellickson and Bell.

Preventing adolescent drug use: long-term results of a junior high program. (1993); Ellickson, Bell, Mcguigan.

Changing adolescent propensities to use drugs: results from project alert. (1993); Ellickson, Bell, Harrison.

Do drug prevention effects persist into high alcohol? How project alert did with 9th Graders. (1993); Bell, Ellickson, Harrison.

Contact:

For curriculum and training:

The BEST Foundation for A Drug-Free Tomorrow
725 S. Figueroa Street, Suite 1615l
Los Angeles, CA 90017
(800) 253-7810
Email: info@projectalert.best.org
Fax: (213) 623-0585
Web site: www. Projectalert.best.org

STARS (Start Taking Alcohol Risks Seriously)

Target Population:

Universal; study #1: 138 6th – 8th Grade students of an inner-city public school in Jacksonville, Florida; 84% African-American; 13% Caucasian.

Selective; study #2: African-American youth.

Setting:

School.

Theoretic Basis:

- Multi-Component Motivational Stages (McMOS);
- Health Belief Model;
- Social Learning Theory;
- Behavioural Self Control Theory.

Program Description:

Focus

Alcohol.

Goals

To prevent alcohol use by inner-city youth; alternative implementation models:

- with brief nurse consultations only (study #1);
- with self- instruction modules and tapes;
- with nurse or physician consultations;
- with peer consultations.

Objectives

- heighten their awareness of preventive issues;
- perform a prevention behaviour;
- practice a prevention skill;
- provide in-depth understanding of essential preventive content, alcohol avoidance and resistance skill building.

Activities

Study #1:

- initial health consultation;
- weekly follow-up consultations.

Study #2:

- self-instruction module;
- nurse or physician follow-up consultation;
- trained peer consultation.

Content

Study #1:

Initial health consultation:

- initial individual health consultation was based on a protocol which included: a stage definition, objective, instructions, introduction, preventive messages, a prescription recommendation and a contract agreement to avoid future alcohol use;
- limited to brief preventive messages.

Six follow-up consultations:

Protocol included: a stage definition, objectives, directions, review of preventive messages related to two targeted risk factor constructs, two or more exercises designed to enhance understanding of the preventive content and build essential resistance skills, and nurse-client contacts with summary and prescription recommendations.

Consultation themes:

1. the environment and situation;
2. behavioural capability and self-efficacy;
3. expectations and expectancies;
4. perceived susceptibility and severity;
5. emotional coping responses and self-reinforcement;
6. self-monitoring and evaluation.

Study #2:

Self-instruction module: posters, fill-in-the-blank gaming sheet, audio tapes with preventive messages, rap music.

Nurse or physician follow-up consultation: use of stage definition, preventive messages, goal statement, prescription recommendations, contract agreement to avoid alcohol.

Trained peer consultation: provided by 8th Grade students using stage-based preventive message sheets to review and reinforce the preventive messages given by the physician or nurse.

Contact Time:

Study #1: initial individual consultation; followed by six, weekly, focused follow-up consultations.

Study #2: one self-instruction module; followed immediately by the health consultation; followed by the peer consultation 2 weeks after post-test.

Leader Type and Training Provided:

The four nurses received an intensive half-day training that included demonstrations, role-playing and feedback from the project staff on how to implement the STARS intervention components. The peer consultants received a half-day of training that included demonstrations, role-playing and feedback from the project staff in Study #2.

Intended Outcomes:

Study #1:

- a series of brief nurse consultations based on the STARS interventions appear to reduce heavy alcohol consumption among urban school youth;
- this was particularly true for a decrease in heavy alcohol consumption;
- the control group showed an increase during this period of time;
- there was a trend but not significant toward fewer intervention students reporting alcohol acquisition stage status and use than control students at post-test.

Study #2:

- holds promise in altering alcohol use and selected behavioural factors associated with alcohol consumption among inner-city youth;
- significant effect on reducing the quantity and frequency of alcohol use among youth during the 10 week follow-up;
- may have changed some risk factors such as: student's perception about the prevalence of adult drinking and their own susceptibility and a greater intention to stop or reduce drinking;
- may have had a greater influence on students who were older and who were not users;
- no effects were found for perceived prevalence in peers, or resistance self-efficacy;
- in terms of satisfaction with the various implementation styles either the physician or nurse consultation was preferable to the peer or self-taught styles.

Author's Comments:

Study #1:

- other alcohol use measures were not affected significantly;
- these interventions could have been too limited in terms of duration, intensity or breadth;
- messages must be reinforced in other settings.

Study #2:

- limited evidence about the effectiveness of nurse vs physician effectiveness;
- needs follow-up on long-term effects.

Reviewer's Comments:

Is quite narrow in scope in and of itself, but could be implemented in tandem with other initiatives; does allow for individual tailoring of program to those with more of an alcohol problem in terms of staging of interventions to individuals.

Year Program Established:

1994-95 School Year.

Associated Studies:

Brief Nurse Consultation for Preventing Alcohol Use Among Urban School Youth. (1996); Werch, Carlson, Pappas, DiClemente.

An Intervention for Preventing Alcohol Use Among Inner-city Middle School Students. (1996); Werch, Anzalone, Brokiewicz, Felker, Carlson, Castellon-Vogel.

Program Sponsors:

Staff:

Centre for Alcohol and Drug Abuse Prevention and Health Promotion, College of Health
University of North Florida
University of Maryland –Baltimore

Funding:

In part by the National Institute on Alcohol Abuse and Alcoholism.

Contact:

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Strengthening Families Program (SFP)

Target Population:

Universal; family intervention for families of Grade 6 students; Selective, for children ages 7 – 11, living in high-risk families; the program has been adapted to be implemented with various cultural groups such as: rural and urban African-Americans, Asian and Pacific Islander families, Hispanic families and rural Junior High families.

Setting:

This program has been implemented in low-income neighbourhood community centres, mental health centers, churches, public housing complexes, drug treatment agencies and hospitals.

Theoretic Basis:

- Biopsychosocial model;
- Family risk and protective models;
- Based on research that has found that family context factors explain more about the variance in the frequency of alcohol use than school context or individual factors;
- Values/attitudes/stressors/coping skills and resources model;
- Social ecology model of adolescent use;
- Resiliency model.

Program Description:

This program is aimed at enhancing the protective factors and reducing the risk factors of families. Timing in terms of developmental stages is critical for intervening in the developmental trajectory of youth. It is a family focused substance abuse prevention program with the goal of delaying the onset of adolescent alcohol use and other behaviours to take advantage of the research finding indicating that odds for dependence decrease by 14% for each year of delayed initiation.

Retention rates have been reported at anywhere between 82 – 85%. Childcare, transportation, meals, payments for testing time, small gifts, family outings and stickers have been used to reduce barriers and provide incentives.

In each 2-hour session the parents and youth work separately for one hour and then together on the family curriculum in the second hour.

The *Parental Focus* is on communication and parenting skills as well as the reduction of their own substance abuse if this is an issue. Parents are taught specifically to relay expectations related to substance use and abuse, understand developmental norms, use appropriate disciplinary practices and manage strong emotions. Observation, direct practice, immediate feedback and videotapes are used to illustrate and reinforce key concepts.

The *Children's Component* consists of many of the same topics as the parents but also includes dealing with peer pressure, compliance with parental rules, dealing with criticism, increasing social competencies, managing emotions and increases knowledge on drugs and alcohol.

During the *Family Hour* the curriculum concentrates on increasing family cohesiveness, and positive involvement of the child in the family. For young children, family's are taught to interact with their children in a positive way through "Child's Game".

Contact Time:

Different lengths of time have been tried with different implementations of the original program. Kumpfer describes a 14-week, once a week curriculum, 2 hours per session for high-risk families, 2 extra weeks are needed for baseline and post program measurements. The Iowa implementation described by Spoth as a universal program is a seven-session program, once a week for 7 weeks, 2 hours per session.

Leader Type and Training Provided:

Each component is led by 2-person teams, requiring 4 trainers per session; no detail on training or background provided; high-quality effective trainers who can manage children with conduct disorders to reduce the potential for negative contagion effects.

Intended Outcomes:

- intervention teens in the universal application showed lower rates of initiation on each of the alcohol ever-use measures at both the 1- and 2- year follow up assessments relative to the control groups;
- generally the reduction rates for families who attended more than half of the sessions were higher than the intervention group as a whole. However at the 2-year follow up, differences did not favour the higher attendance group;
- other outcomes are the reduction of targeted risk factors of family conflict, disorganization and disengagement; improved youth behaviours and reduced expectations about using drugs;
- the use of alcohol and tobacco decreased for older children who were already using;
- parents reduced their drug use and improved parenting efficacy;
- a 5-year study showed evidence of long-term positive impacts on the family and the child such as: an increase in clear directions, quality time spent together and enjoyed, reasonable consequences, scheduled regular play time, family monthly meetings, improved communication and improvements in family problems.

Author's Comments:

- high attendance may not be the only factor involved in the results as it is not clear what role family selection and motivation might have played in these results;
- a developmentally well-timed family intervention, can change the trajectory of alcohol initiation.

Reviewer's Comments:

The universal application study took a number of measures to ensure that methodological methods were addressed. They checked for sample representativeness, evaluated intervention implementation fidelity, assessed effect size, used a model consistent with nesting study design, examined dose related differences, conducted supplemental analyses.

As with other family focused interventions the concentration of this program is on families, bonds between members, strengthening parenting skills and enhancing the life skills of the children. The work with children separately provides an opportunity to examine their perceptions of the benefits and risks of substance abuse and to provide basic information on drugs. They are also taught social and personal management skills.

The program addresses a number of important risk and protective factors specific to the family. The nature of the activities reinforces parent-child and family bonds and develops life long skills and positive attitudes. Leader quality is stressed particularly for the children's component. This interactive program is long enough and with a sufficient level of intensity to produce results.

Year Program Established:

First established in 1983.

Associated Studies:

Alcohol Initiation Outcomes of Universal Family-Focused Preventive Interventions: One and Two-Year Follow-ups of a controlled Study. (1999); Spoth, Redmon, Lepper.

Drug Abuse Prevention Through Family Interventions. (1999); Kumpfer.

Program Sponsors:

Staff:

Institute for Social and Behavioural Research, Iowa State University

Funding:

The National Institute on Drug Abuse
National Institute of Mental Health

Contact:

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Project SixTeen

(based on PATH [Program to Advance Teen Health] and a comprehensive community program)

Target Population:

Grade 6 to Grade 12 students in eight pairs of small (pop = 1700-13,500 people) communities in Oregon.

Setting:

School and community.

Program Description:

Focus

Tobacco.

Goals

To prevent tobacco use in youth.

Objectives

- school component: to deter students from using tobacco and other substances;
- community component: to affect the social influences on adolescent tobacco use.

Activities

- school (PATH): Interactive (see below);
- community: anti tobacco activities; media advocacy; ACCESS – to decrease the availability of tobacco to minors; family communications.

Content:

PATH: 9 levels, 4 levels in Grades 6 to 9 include materials and videos that complement the health education programs of those Grade levels; 5 high school sessions are presented over a one-week period.

Components include:

- health facts and the effect of smoking;
- refusal skills training for dealing with the pressure to smoke, chew, use illegal drugs, or engage in antisocial behaviour;
- video-assisted instruction in presenting key concepts and modeling refusal skills;
- public commitment activities allowing students to clarify their opinions regarding tobacco use;
- peer led discussion and skills practice activities.

Community component: defined by a written module with a menu of activities and instructions.

Media advocacy module: strategies for publicizing the tobacco problem with newspaper articles, fact sheets, advertising, media messages, presentations.

Youth anti-tobacco module: develop anti-tobacco activities that are engaging and persuasive to young people; menu of activities is adapted to each community by the community coordinator and volunteer staff; examples include: sidewalk art, policy review and revision, games, academic presentations, participation in parades.

Family communications module: activities that get parents to tell their kids that they don't want them to smoke; pamphlets that suggest rules and consequences; a tobacco quiz for parents.

ACCESS module: mobilization of community support; merchant education; rewards to clerks for not selling and reminders to those who sell; positive publicity about clerks' refusals to sell; feedback to store owners or managers about the extent of their sales to adolescents.

Contact Time:

PATH: 4 levels Grades 6 to 9; 5 sessions one each day for a week in high school.

Leader Type and Training Provided:

PATH was taught to teachers by project staff in a single session lasting 2-3 hours. It consisted of watching videos, reviewing the activities, practicing or role-playing teaching activities.

The community intervention was conducted by a paid community coordinator, and youth and adult volunteers from the community.

Intended Outcomes:

- provides some support to indicate that a community-wide intervention can improve on the preventive effect of school-based tobacco prevention programs;
- effective tobacco prevention may prevent other substance use;
- the intervention prevented the increase in smoking and alcohol use that was evident in the comparative group;
- significant effects on prevalence of weekly cigarette use in surveys (time) 2 and 5;
- a decrease in smokeless tobacco use by Grade 9 boys at time 2;
- significant effect on alcohol and marijuana use also;
- parents perceived a greater degree of support against smoking by the business community.

Author's Comments:

The important thing about our study is that it shows that a community intervention of the type we implemented can produce stronger preventive effects than a school-based program alone. I would suggest that the parts of our program that are worth implementing elsewhere are the community components: anti-tobacco media, access reduction, youth anti-tobacco activities, and family communications about tobacco.

I have become convinced from my own research and an extensive literature, that there is a core of youth who are at risk for multiple problems including tobacco, alcohol, and other substance use, delinquency, and high-risk sexual behaviour. Too often attempts to prevent substance use are implemented without attention to these other problems, the patterns of behaviour that lead to multiple problems and the risk factors for these early patterns of behaviour that put young people at risk. In particular, there is substantial evidence that the highest risk young people are boys who engage in aggressive and disruptive behaviour at an early age. Thus, in addition to programs that target risk factors specific to tobacco, alcohol, and other drugs, it is important to identify and intervene with young people who are high in aggressive behaviour.

Reviewer's Comments:

In terms of prevention principles emphasized, the program: addresses a number of risk and protective factors; involves youth in the community program and the peer-led activities of the school-based component; addresses a number of life skills, (e.g., communication, resistance skills, involve practice and role-playing); uses an interactive approach; trained leaders and hired special community staffers for the community component; did not vary the intensity for different pockets of the population.

Year Program Established:

1991.

Associated Studies:

A randomized controlled trial of a community intervention to prevent adolescent tobacco use. (2000); Biglan, Ary, Smolkowski, Duncan, Black.

Program Sponsors:

Staff:

Centre for Community Intervention on Childrearing, Oregon Research Institute

Funding:

Grant from the National Cancer Institute

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NOTE: Until June 2001 Dr Biglan is at:

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Saving Lives Program

Target Population:

Universal.

Setting:

Community.

Theoretic Basis:

Multi-strategy community model.

Program Description:

The goal of this program was to organize multiple city departments and private citizens to reduce impaired driving, related driving risks such as speeding and not wearing seat belts, traffic deaths and crashes resulting in injuries.

Communities developed the initiatives for reducing drunk driving and speeding, they included: media campaigns, business information programs, awareness days, speed watch telephone hotlines, police training, high school peer led education, Students Against Drunk Driving chapters, college preventive programs, alcohol free prom nights, beer keg registration and increased liquor outlet surveillance.

To increase seat belt use and pedestrian safety, communities used media campaigns, police checkpoints, posted crosswalk signs, crosswalk guards, preschool education programs and training for hospital and prenatal clinical staff.

Leader Type and Training Provided:

- a full-time coordinator;
- a task force of concerned private citizens, organizations and officials.

Intended Outcomes:

The program cities experienced the following changes relative to the comparison cities in the 5 program years compared to the previous 5 years:

- a 33% decrease in fatal crashes
- a 42% decrease in fatal crashes involving alcohol

These decreases were significantly greater than those that occurred in the rest of the state and in comparison communities. The rate of visible, pedestrian, and total injuries per 100 crashes declined 5%, 10% and 3% more than in the rest of the state. Speeding fines were increased which resulted in a reduction of the number of vehicles observed speeding. The community program produced decreases greater than what was achieved by individual state legal countermeasures. For teens there were fewer incidents of driving after drinking in the program cities.

Author's Comments:

Perhaps the decrease in fatal crashes was more marked than the decrease in injuries decrease in program cities due to the focus of the program; drinking and driving as well as speeding, which are two factors related to traffic fatalities.

Reviewer's Comments:

This program started with accurate data related to traffic violations, seat-belt use and fatalities. They had clear goals about what they wanted the program to influence. They addressed a number of risk and protective factors such as lack of knowledge, strengthening of legislation, point of purchase deterrents and hotlines for reporting speeding which reinforces a community's intolerance for the activity.

Youth were a specific target for the program and as a result they were involved in a number of aspects like safe grad and college prevention programs. It is difficult to determine how comprehensive the programs were in each community as the activities are listed collectively. However the list itself includes an impressive variety of strategies aimed at many levels of prevention.

Year Program Established:

1988 – 1993.

Associated Studies:

Reducing Alcohol-Impaired Driving in Massachusetts: The Saving Lives Program. (1996); Hingson, McGovern, Howland, Heeren, Winter, Zakocs.

Program Sponsors:

Staffing:

Boston University School of Public Health
Governor's Highway Safety Bureau of Massachusetts

Funding:

Grants from:

The Commonwealth Fund
The Massachusetts Governor's Highway Safety Bureau
The National Highway Traffic Safety Administration
The National Institute on Alcohol Abuse and Alcoholism
The Centres for Disease Control and Prevention

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Midwestern Prevention Project (MPP)

Target Population:

Universal (1984); indicated (1987); youth who are already exhibiting use of cigarettes, alcohol and tobacco entering 6th or 7th Grade.

Setting:

Community, school and family based interventions.

Theoretic Basis:

- socially influenced based primary prevention;
- resistance skills training.

Program Description:

Focus

Tobacco, alcohol, marijuana (plus cocaine in later years for the 1998 article).

Goals

- decreased use of tobacco, alcohol and marijuana relative to the risk factors of some of the participants (1990 article);
- decreased levels of substance use among baseline users in 1998 article.

Activities

- combination of processes including interactive homework assignments;
- includes community and parents.

Content

Main Components:

1. School-based component:
   - 10 school-based sessions delivered over a two-year period;
   - teaches skills training for resistance to drug use;
   - psycho-social consequences of drug use;
   - correction of beliefs about prevalence;
   - recognition and counteraction against influences with peers and in the media and community;
   - assertiveness and problem-solving skills;
   - demonstration and rehearsal.

2. Parent component:
   - parents work with their children on homework assignments;
   - students discuss homework assignment in class;
   - parents learn communication skills;
   - parents are encouraged to get involved in community action;
   - role-playing with parents and family members;
   - review of school preventive policies.

3. Community organization:
   - trains community leaders;
   - creation of a formal body that oversees all project activities;
   - includes parents, STAR organizers, other community members.

4. Health policy change: (1998 article)
   - the community organization component develops and implements policy changes that affect alcohol, tobacco, and drug laws;
   - establishes drug free zones.

5. Mass media:
   - used to promote, reinforce and gain support for the project.

Contact Time:

10 school sessions plus the community initiatives.

Intended Outcomes:

1984 application (1990 article):

- significant main effects for the prevention program on monthly (indicates a social use of drugs rather than "problem" use) tobacco and marijuana use in 9th and 10th Grades, 3 years after the delivery of the program;
- no significant effect on alcohol use 3 years later, however a modest effect during the 1 year follow-up;
- prevalence rates increased for all substances; over time the rate of increase for tobacco and marijuana was less for the students in the program;
- the reductions were effective for specific behavioural, social and demographic risk factors.

1987 application (1998 article):

- at 3.5 years follow-up, the program did effect reductions in use;
- more significant results were for tobacco and alcohol;

- tobacco reduction was significant in 6 months to marginal at 2.5 years;
- alcohol effects dropped off after 1.5 years;
- no significant effects were detected among baseline marijuana users, however the program group consistently demonstrated greater reductions in all 3 substances across all follow-ups except for marijuana at the 3.5 year mark.

Original program study:

- students who entered the study in Grade 6 and were measured in Grade 12 showed significantly less substance use;
- tobacco (25% less);
- alcohol (20% less);
- marijuana (30% less);
- participants had an increased perception of their friends intolerance for drug use.

Author's Comments:

Limitations were:

- possible threat to validity of self-reports;
- measurements were limited to a fixed point in time;
- primary prevention may reach a "silent, as yet unidentified" group of early users in a non-stigmatizing manner.

Program materials are not available without training; training can be done in Canada with advance scheduling.

Reviewer's Comment

The most outstanding feature of this program is comprehensiveness in the broad community and family application. Many of the risk factors for substance use are addressed by developing family and community based interventions. This has the added benefit of influencing community awareness and developing less tolerance for substance use.

Life skills are developed with social and resistance skills training specifically. Correcting misconceptions of prevalence of use as part of the curriculum has been shown in other studies to increase the effectiveness of these types of programs. The positive effects of the program are apparent 3 years later which speaks to the maintenance of the skill base.

Year Program Established:

1984; fall 1987.

Associated Studies:

Relative Effectiveness of Comprehensive Community Programming for Drug Abuse Prevention with High-Risk and Low-Risk Adolescents. (1990); Anderson-Johnson, Pentz, Weber, Dwyer, Baer, MacKinnon, Hansen, Flay.

Effects of a Community-Based Prevention Program on Decreasing Drug Use in High-Risk Adolescents. (1998); Chou, Montgomery, Pentz, Rohrbach, Anderson Johnson, Flay, Phil, MacKinnon.

Program Sponsors:

Staff:

Institute of Prevention Research and Department of Preventive Medicine, University of Southern California, LA
Department of Preventive Medicine, Loma Linda University, Loma Linda, California
Prevention Research Centre, School of Public Health, University of Illinois at Chicago
Department of Psychology, Arizona State University, Tempe

Funding:

Grant from the National Institute on Drug Abuse
Grant from the National Institute on Alcohol Abuse and Alcoholism
Research Scientist Development Award

Contact:

(1998 article):

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(1990 article):

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Project Northland

Target Population:

Universal; researched population was students in 6th Grade in 1991 in 24 school districts and adjacent communities in northeastern Minnesota; communities were mostly rural, lower and middle class; seven Indian reservations were in the area (5.5% of the cohort) therefore analysis of results was not possible.

Setting:

School, home, family, and community.

Theoretic Basis:

Based on social cognitive theory as discussed in Bandura (1977; 1986) and extended to adolescent health promotion (Perry & Jessor, 1985).

Targets key social, environmental, personal, and behavioural factors that are predictive of alcohol use among young adolescents.

Program Description:

Focus

Alcohol.

Goal

Preventing or reducing alcohol use among adolescents using a multi-level, multi-year, and community-wide approach.

Objectives

- to increase parent-child communication about alcohol use;
- to change the functional meanings of alcohol use for young people;
- to increase the students' self-efficacy to resist alcohol;
- to decrease peer influences to drink;
- to alter the family and community norms around alcohol use;
- to decrease the students' ease of access to alcohol in their communities;
- to effect a change in the social environment;

Activities/process

- parent involvement;
- education programs - audio tapes, vignettes, group discussions, class games, problem solving and role-playing, normative expectations,
- behavioural curricula;
- peer participation and leadership;
- community task force initiatives.

Content

Each year had a theme and was tailored to the cohort's developmental level and school organization.

Grade 6: Slick Tracy Home Team Program

- four sessions of activity-story books, completed with parents as homework during four consecutive weeks;
- Northland for Parents newsletter with information on teen alcohol use;
- small-group discussions around the themes of the books during school;
- Slick Tracy Family Fun Night- evening fair for families where students' artwork and projects were displayed;
- Task forces were formed and trained - recruited by staff to represent a cross section of the community.

Grade 7: The Amazing Alternatives; (ways to resist and counteract influences on teens to use alcohol)

- kick-off evening with parents
- an 8-week peer and teacher-led classroom curriculum;
- peer participation program to create alternative alcohol-free activities (T.E.E.N.S.- The Exciting and Entertaining Northland Students);
- peer leaders were selected and trained with an open election;
- one-day leadership training;
- four Amazing Alternative program booklets that were sent home to parents with behavioural prescriptions for parents and activities for them to complete with their children;
- 3 issues of "Northland for Parents";
- task force passed 5 alcohol-related ordinances and 3 resolutions and a gold card program with local businesses that provided discounts to students who pledged to be alcohol and drug free.

Grade 8: Power Lines (introduce students to individuals and organizations within the community that influence adolescent alcohol use)

- students interviewed people in the community as part of the 8-session Power Lines curriculum;
- held a town meeting in which small groups of students represented various community groups and made recommendations for community action for alcohol use prevention;
- developed a theatrical production along with a half-day workshop;
- T.E.E.N.S. continued to develop activities;
- TEENSpeak newsletter, written by students and sent to all parents and peers;

- task force had met 28 times during the year, and focused on the following interventions: informing local merchants re policies on alcohol; distribution of materials; assisting gold card program and sponsoring alcohol free activities.

Contact Time:

- 6 classroom sessions in 6 weeks in the 6th Grade;
- 8 classroom sessions in 8 weeks in the 7th Grade;
- 8 classroom sessions in 8 weeks in the 8th Grade;
- ongoing community, school and home activities.

Leader Type and Training Provided:

- peer leaders had a half-day training event in the 7th Grade for Amazing Alternatives;
- students in the TEENS groups were trained in a one-day training event.

Intended Outcomes:

- widespread participation in the program was maintained in all intervention schools;
- nearly half of the students participated in peer-planned alcohol-free activities outside of school;
- for all students and the baseline nonusers the intervention districts had statistically significant lower scores on a scale measuring "less likelihood of drinking";
- past month and past week users were significantly lower in the intervention group who also had lower onset rates;
- use of cigarettes and alcohol in combination was less for the intervention group among baseline non-drinkers;
- the functional meanings of alcohol use were changed;
- peer influence was reduced as well;
- peer norms were altered;
- skills to reduce peer influence were introduced;
- there was increased communication among parents and children about alcohol;
- baseline non-users in Grade 6 were more strongly influenced by their parents and peers not to drink; they reported greater efficacy to resist offers and to affect alcohol related issues.

Program Costs:

The price for all curricula for the 6th-8th Grades is $549.

Authors' Comments:

- despite the impact for baseline non-users, little significant difference was noted for the users at baseline; however, these represented a minority of students;
- reinforces the difficulty of reversing behaviour even at Grade 6;
- prior behaviour is the strongest indicator of future behaviour;

- interventions for this group may need to focus on reasons for pre-adolescent use and start before the 6th Grade;
- social barriers and social opportunities, plus enforced community regulations reducing access may be as critical for this group as personal factors.

Reviewer's Comments:

The results for users are disappointing; demonstrates the need to start preventive efforts before Grade 6; the extensiveness of the program on so many fronts is impressive.

Ways in which prevention principles were most reflected: baseline information on users and non users was very important; youth were involved in many aspects of the program; addressed a significant number of protective and risk factors, including legislation at the local level, as well as societal norms; the multi-strategy, multiple settings approach was very comprehensive; life-skills training was included; teacher training was held for one full day each year for each of the curricula; the school program was intensive at times and although shorter in duration than some school-based programs, it was supported by the family and community efforts outside of school.

Year Program Established:

Implemented for 3 years 1991-1994.

Associated Studies:

Project Northland: Outcomes of a Community wide Alcohol Use Prevention Program during Early Adolescence. (1996); Perry, Williams, Veblen-Mortenson, Toomy, Komro, Anstine, Mcgovern, Finnegan, Forster, Wagenaar, Wolfson.

Program Sponsors:

Staff:

School of Public Health, University of Minnesota
National Institute on Alcohol Abuse and Alcoholism

Contact:

These materials can be obtained from Hazelden Publishing. Their web address is: www.htbookplace.org. Their phone number is 1-800-328-9000.

All of the program components were written in teacher- and peer leader-friendly manuals with all needed accompanying materials. Training for all programs is being conducted by Hazelden Publishing.

LIFESTYLES 94

Target Population:

Indicated; first-year college students who are heavy drinkers.

Setting:

Post secondary.

Theoretic Basis:

- social–cognitive;
- harm reduction.

Program Description:

The goals of this individualized "stepped care prevention model" program are to reduce the harmful effects of alcohol abuse in college students who show a pattern of binge drinking as well as to prevent the development of alcohol dependence in high-risk drinkers.

The motivational/feedback intervention is a brief non-confrontational feedback and advice session that serves as a "first step". The hope is that this session will build rapport with students and provide access to them, eventually facilitating the move into other more intensive treatments.

A professional staff member meets with each student alone to review their self- monitoring and give feedback about drinking patterns. Drinking rates are compared to averages and risks for current and future problems are identified. Beliefs about alcohol effects are discussed in the context of placebo effects and effects on social behaviour. Biphasic effects are described and suggestions for reduction are outlined.

In this technique the evidence is placed before the students and they are prompted to evaluate their own situation and contemplate the possibility of change. This format treats the students as adults who are responsible for their own behaviour and for finding a solution. The information is very specific to each person and they are given a feedback sheet and a tips page when they leave. By "stepping down" the harm incrementally, drinkers can be encouraged to pursue moderation or abstinence.

Contact Time:

One interview of an unstated amount of time.

Leader Type and Training Provided:

A professional motivational interviewer.

Intended Outcomes:

- at the 3-month mark the interviewed group showed less drinking than the controls;
- all students showed a reduction but the intervention group had continually significantly greater reductions;

- the treatment is effective for all students regardless of risk.

Author's Comments:

- male students with conduct disorders or delinquent behaviours who lived in fraternity houses reported more alcohol-related problems at all points in time;
- women as a group had a developmental trend downward for drinking-related problems that was enhanced by the program.

Reviewer's Comments:

One of the most prominent features of this program is the focus on individuals and their specific drinking patterns and situation. The format is based on an interactive discussion and the provision of information by a trained professional. This is a youth-driven intervention in which they are actively involved in analyzing their own situation, their perceived risks and benefits as well as developing their own plan for reduction.

They are provided with accurate information about the prevalence of drinking for their age cohort and can compare this with their own drinking pattern. Although the duration is short, the intervention is specifically related to the individual's risk and protective factors, therefore the message has impact.

Year Program Established:

1994.

Associated Studies:

Harm reduction and Alcohol Abuse: A brief intervention for college-student binge drinking. (1997); Marlatt, Baer.

Program Sponsors:

Staffing:

Addictive Behaviours Research Centre, University of Washington

Funding:

A Research Scientist Award
A MERIT Award
Grant from the National Institute on Alcohol Abuse and Alcoholism

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Opening Doors

Target Population:

Selected; at-risk youth in their transition years (i.e. Grades 8 – 10).

Setting:

School; family; community.

Theoretical Basis:

Social competence skill training approach.

Program Description:

The goal of this in-school program is to prevent and/or reduce a variety of problems including: truancy, violence, substance use and other anti-social behaviours among at risk youth in their transition years. Short-term goals include improvements in academic achievement and positive attitudes toward school, increases in self-esteem, self-concept, and perceived competency; favorable changes in attitudes toward alcohol and other drug use; improved coping, peer refusal and social skills; and enhancement of positive peer and family interactions.

The consenting students complete a self-report questionnaire that serves as a screening tool. About 10 – 12 students are then selected for the program based on their "at-risk " status. These students are invited to attend the program.

Parents of the selected students are also invited to attend a parent program for five sessions (2 hours each), held alternate weeks while the student program is in effect. This program's goals are to foster a home environment were parents support and reinforce their children's school experience and their efforts to make lifestyle changes. Improved parent and child interactions, better management of behavioural problems and reinforcement and support for the student's program were other expected outcomes.

The student sessions focused on knowledge of specific drugs and potential adverse consequences, communication skills, stress and anger management, improved relations with peers and family, fostering positive attitudes toward school and academic achievement, improved self-esteem and perceived competency, social skills, goal setting and goal attainment skills, decision-making and problem-solving skills and peer-refusal skills.

Contact Time:

Over 10 weeks, 17 one- to two-hour sessions.

Leader Type and Training Provided:

Leaders undertook an intensive training program lasting 2-3 days; sessions were conducted by teams with one usually associated with the school (e.g., a guidance counsellor or youth worker) and a community agency person (e.g., public health nurse, youth worker).

Intended Outcomes:

Between 20 to 25% of all students tested were at risk for experiencing drug use, truancy, behavioural problems at school, violent and other anti-social behaviour.

- program participants reported less frequent drinking, cannabis use, non-prescription tranquilizer and sedative use and self-reported theft as well as improved attitudes toward school (post-test only);
- they also were less supportive of alcohol, tobacco and cannabis use and risky drinking behaviour (post-test and follow-up);
- there were no program effects for personal and social competence of life-skills measures like self- esteem and perceived competency;
- after 6 months many of the beneficial effects had weakened or disappeared.

Program Costs:

- costs to school and community agency: approximately $65 to purchase kit (program leader manuals for students and parents; parent booklet entitled "There's a Teenager In My Home"; promotional video of program);
- $100 per person to attend training;
- approximately $200 per school to purchase resource materials for student and parent sessions;
- computerized screening method currently under development.

Author's Comments:

- the risk profile of the students may help explain the lack of effect in the social and personal realms;
- the use of community health care professionals may have contributed to the positive findings in that they are removed from the school situation and are potentially better able to establish a warm working relationship with the students;
- the program experienced high attendance and retention rates;
- the voluntary nature of the program opened the door to the problem of self-selection;
- some effects may be due to non-equivalence of students caused by differential attrition across time;
- the lack of maintenance and some of the less desirable outcomes may be the result of deviant peer bonding;
- singling out students for the program may increase the risk of negative social labeling;
- the Hawthorne effect may also have been at work here in terms of increased attention.

Reviewer's Comments:

This program emphasizes a number of prevention principles. The format and discussions incorporated into the sessions on drugs provide accurate information and messages in a format that is fun for youth. The material is appropriate to the developmental benchmarks of young people and all the exercises and games are geared toward the use of key principles that are

continually reinforced. The process is very interactive and the activities are based on cooperative and team efforts. The program runs for the better part of a term allowing for adequate presentation and reinforcement of the material. Special attention has been paid to the training and selection of the leaders, promoting the use of a non-school related leader when possible. The program uses a comprehensive approach, involving school, family and community.

Year Program Established:

1993-94 Research Study

1997 – present: implemented across Ontario.

Associated Studies:

Dewit, D., Ellis, K., Rye, BJ, Steep, B, Braun, K., Heathcote, J., Silverman, G., Smythe, C., Stevens-Lavigne, A, & Wild, C. (1998). "Evaluations of opening doors, a drug prevention program for at-risk youth: three reports. Addiction Research Foundation. ARF research document series no. 143 Toronto, Ontario.

Dewit, D., Braun, K.,Ellis, K., Rye, BJ, ., Silverman, G, Smythe, C.,Steep, B, Stevens-lavigne, A (2000). Evaluation of an in-school drug prevention program for at-risk youth in their transition years. Alberta Journal of Educational Research, xlvi, no 2. 117-133.

Program Sponsors:

Staffing and funding:

Centre for Addiction and Mental Health, Toronto

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Personal Growth Class

Target Population:

Indicated; high school youth (Grades 9 – 12) who are actual or potential dropouts.

Setting:

School.

Theoretic basis:

- social network support theories;
- social control, strain and learning theories.

Program Description:

The original PGC is designed to reduce adolescent drug involvement and to increase school performance and emotional well-being in high-risk youth that either have dropped out or have the potential to do so. In later applications, the program was refined to address underestimated levels of depression and related mental health problems and to ensure that core components were emphasized consistently.

Based on the theory that adolescent behaviours are shaped and reinforced within a social network of social relations, the base program focused on two areas, social support and life-skills training. The peer group was the context for the support component, which consisted of group support, friendship development and school bonding through student-teacher bonding and teacher modeling.

There are four skills training units: self-esteem, decision-making, personal control, and interpersonal communication. Each unit follows a logical transition from introduction, skills development, application and transfer and relapse prevention. Each skill is applied to problems brought out in the group itself as well as in the context of the program goals of reduced substance use, improved school performance and mood management.

The program concentrates on individual skill development first and then moves to interpersonal and interactional skills in order to parallel the group development processes. A positive peer culture is promoted through support and caring, meeting the needs of the group and individuals, monitoring ones behaviour, motivating youth to change and setting personal and group goals.

The revised version is based on leanings from the original application, namely: the program needed to be more consistently delivered and needed to address the high levels of depression and suicidal ideation that emerged. As a result the skills training component was enhanced to include managing depression, anger and suicidal behaviours. Also the units were reorganized and re-sequenced to add more personal control content and remove the career development unit.

Contact Time:

- one semester, 5-month elective course;
- within the context of the regular high school curriculum;
- daily for 55 minutes for 90 days.

Leader Type and Training Provided:

Teachers (12:1 ratio) were selected who were experienced and skilled, then intensely trained prior to program implementation. The training consisted of a 3-day workshop by the investigators as well as biweekly meetings to discuss topics identified and provide ongoing support and peer consultation. Half-day planning and evaluation sessions were held at the beginning and end of the semester. The teachers were monitored weekly by a school counselor and program director in order to determine the fidelity of the program implementation.

Intended Outcomes:

In the original version of the program, participants showed reduced drug-use and drug-control problems as well as increased school performance. The participants also showed improvements in self-esteem and enhanced school bonding. Once the program ended, the effects were less consistently sustained. The program was more effective in decreasing drug use behaviours than reversing the progression of actual drug use.

The refined version did not improve on these results, however there was reduced frequency of hard-drug use and reduced levels of depression, anger, stress and increased levels of self-esteem. The curriculum enhancements which integrated skills training applied to drug involvement all through the program, decreased hard-drug use and thus helped to stem the progression from legal to illicit drugs.

Specific skill training within the context of a multifaceted intervention works because it meets the specific needs of high-risk youth.

Author's comments:

- need to refine our knowledge of what works for which adolescent behaviours;
- anger and depression management skills promote ameliorative effects;
- participants responded well to the emotional well-being content.

Reviewer's Comments:

Noteworthy program because it addressed the needs of a group who were at the edge of the cliff. This was the last chance for the system to make a difference for them. The program was carefully and specifically designed to meet their needs. Substance abuse reduction was in some degree a secondary benefit of the other goals of the program that had to do with the many risk factors leading to substance abuse. The emotional state of the students was taken into account and addressed.

In terms of prevention principles emphasized, this program, especially the refined version, was based on clear data about the needs of the specific population being served. The goals were very clear and broad, taking into account the many complex factors that lead to substance abuse in terms of school bonding and performance, lack of peer and social support systems and the presence of depression and uncontrolled anger without the skills to deal with it appropriately.

The indicated target group was well defined and carefully selected based on a number of criteria. The program was geared to the specific needs of the target group and was therefore intensive, being offered every day for a whole semester. I felt it was important that the course be integrated into the regular course offerings and that the students receive credit. The teachers were especially selected for their skills and were trained and monitored to ensure consistent program implementation.

Associated Studies:

Preventing Adolescent Drug Abuse and High School Dropout through an Intensive School-Based Social Network Development Program. (1994); Eggert, Thompson, Herting , Nicholas, Dicker

Enhancing Outcomes in an Indicated Drug Prevention Program for High-Risk Youth. (1997); Thompson, Horn, Herting, Eggert,

Program Sponsors:

Staffing:

Reconnecting At-Risk Youth Research Programs at the:
University of Washington, Seattle
Stanford University, Stanford
Bellevue Public Schools, Bellevue, Washington

Funding:

Grant from the National Institute on Drug Abuse
Grant from the National Institute of Mental Health

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Project Toward No Drug Abuse (TND)

Target Population:

Indicated; continuation high schools in southern California; youth at a continuation high school are therefore exposed to a direct environmental risk due to minority status, friend and family drug use or regular drug use themselves; youth who are unable to remain in the regular school system for functional reasons, including substance abuse. Students are at risk for drop out and drugs are at a higher level of use.

Setting:

School and community.

Theoretic Basis:

Health motivation; social and self-control skills; decision-making as the basis for violence and drug abuse prevention.

Program Description:

Focus

Tobacco, marijuana, alcohol and hard drug use.

Goals

To positively effect changes in substance use in a high-risk group.

Objectives

- motivate students to resist temptation;
- teach skills that help them resist;
- provide health behaviour-decision-making strategies that tie motivations to skills.

Activities

Interactive:

- health motivation messages;
- social skills;
- decision-making approach;
- planning school activities;
- school as community component.

Content

School component:

Classes 1-3:

- motivates students to listen to pro-health programming and provides listening skills (listening, stereotyping, and drug use myths and denial sessions).

Classes 4-6:

- chemical dependency issues instruction;
- alternative coping skills (stages of chemical dependency, talk show on consequences, stress coping sessions).

Classes 7-9:

- making non-drug use choices (self-control skills, taking a moderate perspective, decision-making and commitment sessions).

Classes 10-12:

- marijuana panel, tobacco, basketball and cessation; positive and negative thought and behaviour loops.

School as community component:

- implementation of weekly Associated Student Body Core Group meetings for 6 months;
- six events per school (e.g., job training, sports, drug-free parties, drug awareness week);
- distribution of a community newsletter.

Contact Time:

Three 50-minute sessions per week for 3 consecutive weeks.

Leader Type and Training Provided:

Nine project staff health educators were assigned to instruct at the schools; trained by the project manager by instruction for 2 ½ hours for each session; each session was practiced and observed once. The school as community component was implemented by a volunteer school staff member under project-created guidelines.

Intended Outcomes:

- at 1-year follow-up the program led to a significant reduction in hard drug use and reduction in alcohol use among pretest users;
- no reductions in marijuana or tobacco use;
- students showed learning of the material and reported high interest and belief in the material;
- most consistent effects were for hard drug use;
- the school as community component did not appear to add much to the effect of the classroom program;
- findings did not show relevant gender or ethnic effects which might have suggested limits of generalizability.

Program Costs:

The following is included in the complete set of curriculum materials:

- An implementation teacher's manual providing step-by-step instructions for completing each of the twelve core lessons with introductory and background material. $50 each, plus shipping and handling;
- One video "Drugs and Life Dreams," emphasizing empowerment and produced specifically to support Session 12 of the curriculum; the video is $40.00;
- A student workbook. Set of five for $25, plus shipping and handling. Add 10% to order of 30-500; add 9% to order of over $500;
- Training is available at a fee of $500/day plus expenses;
- To order teacher's manual and student workbooks, or to request training, contact Fran Deas at 323-442-2594 or e-mail her at Deas@hsc.usc.edu.

Author's Comments:

Regarding the study:

- the high-risk status of the students was confirmed by the current drug use statistics as compared
- to regular high schools;
- typical social influence activities are not preferred by continuation high school students, adaptation and the addition of components was necessary (e.g., coping skills, recovery movement ideas, and motivation activities);
- it is possible that youth perceive tobacco and marijuana as relatively safe (also tobacco is highly addictive);
- hard drugs on the other hand are considered dangerous possibly leading to overdose, sickness or death, they are also harder to obtain;
- perhaps too few students participated in the school as community program to reach a "threshold of involvement".

Regarding the program:

- to be successful, it should be teacher led, classroom based;
- a school as community component provides no incremental effect above and beyond a classroom-based only program;
- it is possible to engage alternative high school youth in effective indicated drug abuse programming, with good follow-up;
- effects generalize to comprehensive high school youth;
- long-term follow-up results are forthcoming;
- the cognitive perception and behavioural skills components will be tested in a newly funded grant (as component programs).

Three Prevention Principles Most Reflected by TND: addressed how youth view drug use protective and risk factors, ensured sufficient program duration and intensity, carefully evaluated through three experimental field trials.

Reviewer's Comments:

Interesting and impressive results with high-risk students with hard drug use and alcohol; adaptations had to be made from the model programs used as a base.

Prevention principles emphasized: program addressed a number of risk and protective factors in the high-risk group; program was comprehensive in that a range of interventions and activities were used; activities were didactic and interactive; life skills regarding decision-making and resistance skills were taught; the intensity and duration were less than other programs of this type; the leaders were given fairly extensive training on each of the modules; the population was clear and specific; in working with this indicated population concentrated effort went into customizing the curriculum.

Year Program Established:

1994-95 school year.

Associated Studies:

One Year Outcomes of Project Towards No Drug Abuse. (1998); Sussman, Dent, Stacy, Craig.

Program Sponsors:

Staffing:

Institute for Health Promotion and Disease Prevention Research
Department of Preventive Medicine, University of Southern California, L.A.

Funding:

Grant from the National Institute on Drug Abuse

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Seattle Social Development Project Intervention

(Commercially available as "SOAR")

Target Population:

Selective; focused on a population at elevated risk for adolescent health risk behaviours; students in Grades 1- 6 in 18 public schools serving a high-crime area of Seattle, Washington; follow-up at 18 years of age.

Setting:

School and family.

Theoretic Basis:

- social development model, an integrated theory of human behaviour;
- theory is that strong bonds to school serve as a protective factor against behaviours that violate socially accepted standards;
- attachment and commitment are components of such social bonds;
- early and sustained intervention through the elementary Grades should put children on a different developmental trajectory leading to positive outcomes over the long term.

Program Description:

Focus

Diverse health risk behaviours that are a threat to adolescents.

Goals

- to increase bonding to school and academic success;
- to prevent a broad range of health-risk behaviours in a multi-ethnic urban setting.

Objectives

Reduce:

- persistent physically aggressive behaviour in the early elementary school grades;
- poor family management practices including: unclear rules, poor monitoring of behaviour and inconsistent or harsh discipline.

Improve

- children's attitudes toward school;
- children's behaviour at school;
- academic achievement;
- bonding to school.

Activities

- combined interactive and non-interactive;
- includes providing opportunities for children to increase their active involvement in the family and classroom;
- classroom and family management activities and altered attitudes.

Content

Classroom instruction and management:

- proactive classroom management;
- interactive teaching;
- cooperative learning.

Child skill development: (for 1st Grade teachers)

- use of a cognitive and social skills training curriculum;
- interpersonal cognitive problem solving: teaching children to think through and use alternative solutions to problems with peers;
- skill development for cooperative learning groups and other social activities.

Parent intervention:

- offered on a voluntary basis to parents or adult caregivers;
- Grades 1 and 2– "Soaring Stars" – child behaviour management skills, 5 sessions;
- Grades 2 and 3 – "Preparing for School Success" – supporting their child's academic achievements – 5 sessions;
- Grades 5 and 6 – "Preparing for the Drug Free Years" – to assist them to reduce their children's risk for drug use - 5 sessions.

Contact Time:

Not specified, with the exception of a 4-hour training session by project staff when the students were in Grade 6, on skills to recognize and resist social influences to engage in problem behaviours and to generate and suggest positive alternatives to stay out of trouble while keeping friends; no booster sessions were offered. Contact with parents as above.

Leader Type and Training Provided:

Each year of the intervention teachers were given 4-5 days of intensive training and 4 days annually of follow-up visitations by trainers. Parents – see above.

Intended Outcomes:

Observations of teachers for two, 50-minute periods in both the Spring and Fall of each year showed that intervention teachers used the experimental instructional and management methods more than the controls. Training parents and teachers to promote children's academic competencies, bonding to school, development of children's social competencies, and skills to resist health-compromising influences produced:

- greater commitment and attachment to school;
- less school misbehaviour;
- better academic achievement 6 years after the intervention;
- a reduction in the lifetime prevalence of violent criminal behaviour, heavy drinking, sexual intercourse and pregnancy;
- starting at elementary school entry and continuing through Grade 6, had greater effects on both educational outcomes and health-risk behaviours than intervening later in the elementary grades;
- no significant effects were found for measures of drug use, nor did measures of heavy cigarette and marijuana use differ significantly across the group at age 18 years.

Reviewer's Comments:

Use of a multiple component strategy with teachers, parents and children appears necessary to affect the broad risk factors of concern; very interesting because of the early start and ongoing attention during the first 6 years of school; the focus was on increasing school bonding and achievement rather than on developing norms and it worked for a broader range of risks than substance use alone. Follow-up results seem impressive given that the results were 6 years later with no booster sessions.

With respect to prevention principles emphasized, the program gave attention to a broad range of adolescent risk behaviours; the duration of the intervention was very long (6 years); due to the nature of the intervention which focused on context more than content for the students at least, it is difficult to comment on intensity; addressed a number of risk and protective factors related to how children were treated and managed in both the home and classroom; there was some focus on life skills for resisting the influences in Grade 6; the program was comprehensive in that it operated in both the home and classroom; the teachers and parents were trained in methods and techniques at various stages throughout the intervention; the target population was selected for its high-risk environments.

Year Program Established:

Intervention initiated in 1981 at 1st Grade; follow-up at 18 years 1993; commercially available in 2001.

Associated Studies:

Preventing Adolescent Health Risk Behaviours by Strengthening Protection During Childhood. (1999); Hawkins, Catalano, Kosterman, Abbott, Hill.

Program Sponsors:

Staff:

Social Development Research Group, University of Washington, Seattle

Funding:

National Institute on Drug Abuse, Rockville, MD
Office of Juvenile Justice and Delinquency Prevention, Washington, D.C.
Robert Wood Johnson Foundation, Princeton, NJ

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Skills Training for College Students

Target Population:

Selected; young adults, mean age = 23; at risk for alcohol problems; self-selected by an ad in the newspaper and then screened by the use of questionnaires; students with moderate to severe alcohol dependency were screened out.

Setting:

Post secondary.

Program Description:

Focus

Alcohol.

Goals

To reduce the amount and moderate the pattern of alcohol consumption among college drinkers.

Objectives

To foster the development of self control, responsible decision-making, and coping skills.

Activities

- interaction among students and instructors was encouraged;
- special discussions of weekly self-monitored drinking;
- skills training.

Content

Eight sessions:

- models of addiction and the immediate and delayed effects of drinking;
- training in estimation of base alcohol level, drinking moderation skills, setting limits;
- relaxation training and alternative self-rewarding behaviours;
- nutrition information and suggestions on aerobic exercise as a method of moderating consumption;
- antecedents of heavy drinking and recognition and response to situations involving increased risk of overdrinking;
- assertiveness and drink refusal skills;
- a situation with a placebo in a simulated tavern, to identify alcohol-related expectations and pleasurable effects of the setting;
- relapse preventive strategies.

Contact Time:

- 7 – 10 days of baseline monitoring;
- 8 – 90-minute weekly meetings on the above themes;
- all subjects self-monitored their drinking daily.

Theoretic basis:

Cognitive-behavioural; social learning theory; skills training model; risk reduction; harm minimization.

Leader Type and Training Provided:

Male and female pairs including two doctoral level clinical psychologists and one advanced clinical psychology student.

Intended Outcomes:

- found a significant reduction over one-year follow-up in several measures of self-reported alcohol use for the total sample;
- for all measures directional findings favoured the skills training;
- most subjects continued to report occasional heavy drinking;
- no evidence of a significant change in alcohol-related life problems;
- subsequent studies have followed subjects for 2 and 4 years and have found the brief motivational intervention to be no less effective than the group format.

Author's Comments:

With respect to the prevention principles, this work supports a stronger emphasis on assessment and individualized feedback in the context of a non-judgmental motivational interviewing session. A number of other of the Compendium's identified principles (e.g., "Use interactive group process", "Ensure sufficient program duration and intensity") may be useful with some groups of youth, but based on these findings would not appear to be necessary to achieve sustained harm reduction, at least in the university setting.

Reviewer's Comments:

Given the effectiveness of normative training with high school students, it may have been useful to include information on peer norms with this post secondary population, who by virtue of their age and maturity, may have a still greater appreciation for this information.

With respect to the prevention principles emphasized: a significant amount of information relating to the students drinking patterns was collected in the initial assessment and screening phase; the goals were clear and reasonable in terms of harm reduction; the program addressed a number of risk and protective factors such as skills training and addressing expectations of alcohol's effect and the impact of the environment on mood and attitude; there was some life skill training that included nutrition information and alternative ways to provide relaxation; the

leaders were well trained in psychology but the details of their training relating to the actual program were not given; the program was quite intense and lasted for 8 weeks, the self monitoring component would extend the impact of the weekly meetings; the program was designed for the selected population and aimed at harm reduction and risk management.

Associated Studies:

Kivlahan, D.R., Marlatt, G.A., Fromme, K., Coppel, D.B. & Williams, E. (1990). Secondary prevention with college drinkers: Evaluation of an alcohol skills training program. Journal of Consulting and Clinical Psychology, 58, 805-810)

Baer, J.S., Marlatt, G.A., Kivlahan, D.R., Fromme, K., Larimer, M. & Williams, E. (1992). An experimental test of three methods of alcohol risk-reduction with young adults. Journal of Consulting and Clinical Psychology, 60, 974-979).

Marlatt, G.A., Baer, J.S., Kivlahan, D.R., Dimeff, L.A., Larimer, M.E., Quigley, L.A., Somers, J.M., & Williams, E. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a two-year follow-up assessment. Journal of Consulting and Clinical Psychology, 66, 604-615)

Roberts, L.J., Neal, D.J., Kivlahan, D.R., Baer, J.S., & Marlatt, G.A. (2000). Individual drinking changes following a brief intervention among college students: Clinical significance in an indicated preventive context. Journal of Consulting and Clinical Psychology, 68, 500-505.).

Baer, J.S., Kivlahan, D.R., Blume, A.W., McKnight, P., & Marlatt, G.A. (in press). Brief intervention for heavy drinking college students: Four-year follow-up and natural history. American Journal of Public Health).

Program Sponsors:

Staff:

Department of Psychiatry and Behavioural Sciences, University of Washington
Department of Veterans Affairs Medical Center, Seattle
Addictive Behaviours Research Centre, University of Washington

Funding:

Grant from the National Institute on Alcohol Abuse and Alcoholism

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Social Competence Promotion Program for Young Adolescents

Target Population:

A total of 282 6th and 7th Grade students; inner-city middle school (primarily a group of black students); suburban middle school (primarily a group of white students); both in south central Connecticut.

Setting:

School-based.

Theoretic Basis:

Cognitive-behavioural.

Program Description:

Focus

Skills, social adjustment and alcohol use.

Goals

Promote personal and social competence to affect self-reported substance abuse by 6th and 7th Graders.

Objectives

Enhance personal and interpersonal effectiveness and to prevent the development of maladaptive behaviour through:

- providing students with developmentally appropriate skills and information;
- fostering prosocial and health-enhancing values and beliefs;
- creating environmental support to reinforce the real-life application of skills.

Activities

- general competence enhancement;
- domain-specific instruction;
- application to substance abuse;
- techniques: didactic instruction, class discussion, videotapes, diaries, small group role-playing, work sheets, homework assignments, real-life social tasks.

Content

Sequential and integrated program has three modules:

- Social problem solving skills training (27 lessons);
- Substance abuse prevention (9 lessons);
- Human growth and development and sex education (9 lessons).

Topics

- stress management – symptoms and coping strategies;
- self-esteem – positive personal attributes and goal setting;
- problem solving – social problem-solving framework;
- substances and health – physical, social and legal consequences of substance abuse;
- assertiveness – assertive communication and resisting pressure;
- social networks – supports in their schools, communities and homes.

Contact Time:

45 session program; 3 modules; two or three 45-minute periods every week over a 20-week period.

Leader Type and Training Provided:

Master level health educators, from a university-based community agency co-taught with classroom teachers; both the teachers and the health educators received training by program developers through a series of 3-day introductory workshops, ten – 2-hour workshops, as well as weekly on-site consultation throughout program implementation.

Intended Outcomes:

The two samples differed on a number of variables at the time of preassessment:

- suburban sample reported a greater intention to experiment with substances and higher substance use rates;
- suburban also demonstrated more adaptive means of coping with stress;
- inner-city generated more effective solutions to a hypothetical peer pressure situation.

Program students:

- improved the quantity and effectiveness of their coping skills in response to a hypothetical peer pressure situation and a more general stress-inducing situation;
- improved social adjustment and interpersonal effectiveness;
- teacher ratings of adjustment improved significantly;
- self-reported adjustment was also enhanced;
- intentions: program students remained relatively stable in their self-reported intentions to use beer and hard liquor as compared to the controls who were more inclined to use;
- experimental use: no measurable effect;
- excessive use: positive effects.

Authors Comments:

The effect on excessive drinking may indicate that the program may equip students with the critical thinking skills to realize that abusing alcohol is harmful. Follow-up assessments would be informative to measure future effects and long-term behavioural adjustment. There were comparable results across both the inner-city and suburban samples. Information and skills acquired may need continued reinforcement and refinement as a student progresses through the adolescent years. This program has been incorporated into the larger New Haven Social Development Program that is a K to 12 comprehensive effort.

Reviewer's Comments:

The involvement of peer leaders may have improved the outcomes.

In terms of prevention principles, the program addressed a number of risk and protective factors; it contained interactive and practical application skills training. The program was relatively comprehensive; the training was intensive and went on for 15 weeks, however there were no booster sessions to reinforce the learning, an adaptation the authors themselves felt would strengthen the program. There was a focus on teaching problem-solving skills that if reinforced could provide life-long benefit; the trainers underwent a fairly comprehensive training period and came to the program with an appropriate background in education and experience. Youth were not involved in the delivery of the program.

Year Program Established:

Article 1992; the program was developed between 1985 and 1990.

Associated Studies:

Caplan, M., & Weissberg, R. P. (1990). The substance use prevention module of the Yale-New Haven Social Development Program. New Haven, CT: Yale University.

Caplan, M., Weissberg, R. P., Grober, J. H., Sivo, P. J., Grady, K., & Jacoby, C. (1992). Social competence promotion with inner-city and suburban young adolescents: Effects on social adjustment and alcohol use. Journal of Consulting and Clinical Psychology, 60: 56-63.

Kavanagh, M., Jackson, A. S., Gaffney, J., Caplan, M., & Weissberg, R. P. (1990). The human growth and development, AIDS prevention, and teen pregnancy prevention module of the Yale-New Haven Social Development Program. New Haven, CT: Yale University.

Weissberg, R. P., Barton, H. A., & Shriver, T. P. (1997). The Social-Competence Promotion Program for Young Adolescents. In G. W. Albee & T. P. Gullotta (Eds.), Primary prevention exemplars: The Lela Rowland Awards (pp. 268-290). Thousand Oaks, CA: Sage.

Weissberg, R. P., Caplan, M., Bennetto, L., & Jackson, A. S. (1990). The New Haven Social Development Program: Sixth-Grade social problem-solving module. New Haven, CT: Yale University.

Weissberg, R. P., Jackson, A. S., & Shriver, T. P. (1993). Promoting positive social development and health practices in young urban adolescents. In M. J. Elias (Ed.), Social decision making and life skills development: Guidelines for middle school educators (pp. 45-77). Gaithersburg, MD: Aspen Publications.

Weissberg, R. P., Shriver, T. P., Bose, S., & DeFalco, K. (1997). Creating a districtwide social development project. Educational Leadership, 54

Program Sponsors:

Support by:

Connecticut Department of Children and Youth Services
Catherine T. MacArthur Foundation Health and Behaviour Network
William T. Grant Foundation Faculty Scholars Program in Mental Health of Children

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Adolescent Transitions Program (ATP)

Target Population:

Low income at risk families of children in 6th to 8th Grades (mean age 12).

Setting:

Families in groups.

Program Description:

The study subjects were divided into 4 intervention groups: parent only, teen only, parent and teen focus and self-directed change.

The intervention consisted of two curricula, a parent intervention and a teen intervention. Families attended 90-minute, weekly meetings for 12 weeks.

The parent intervention consisted of four key concepts: monitoring, positive reinforcement, limit setting and problem solving. The goal is for parents to develop effective parenting skills and strategies. Usually 8 families or potentially 16 parents were in each group. A standard curriculum was implemented including: a discussion of what went on the week before, the introduction of a new skill followed by exercises, role-playing and discussion.

A teen focus curriculum was designed to enhance the teenager's regulation of behaviour in the context of peer and parental environments. Deficits in self-regulation are central to a perspective of addiction. The following skills were the focus of the teen component: self-monitoring and tracking, prosocial goal setting, setting limits with friends, problem solving, and communication. Teens decided on their own behavioural goals. Many selected improved school performance, abstinence from drug experimentation and improved family relations.

Contact Time:

Each family received three individual consultation sessions and 12 weekly 90-minute group sessions completed in 3-4 months.

Theoretic Basis:

- social learning parent training;
- psycho-educational format.

Leader Type and Training Provided:

Therapists conducted the training with the assistance of parent co-leaders in the parent focus sessions.

Intended Outcomes:

Families who were in the teen or parent intervention group reduced their coercive interactions and this had a positive impact on their family's functioning.

There were immediate benefits to family functioning for the teen focus curriculum, however this group had a reliable trend toward more favorable attitudes to substance use. By 1- year follow-up, teachers rated them as having more behavioural problems than the other groups. Research supports the high correlation between deviant peer exposure and problem behaviour.

Author's Comments:

- the key to success in developing contextual interventions is to engineer collaboration between school staff and parents;
- social skill interventions that group high-risk teens may actually serve to increase contact with deviant peers for some youth and exacerbate their adjustment.

Reviewer's Comments:

This program aims to have an influence on family relationships and parenting skills in order to address some of the risk and protective factors associated with substance abuse and antisocial behaviour. It uses a number of strategies with the families individually and both parents and teens in groups to implement the elements of the social learning curriculum. It takes an environmental and peer influence approach with the teens in order to increase their skills at self-regulation, monitoring and goal setting. The program allowed the teens to set their own behavioural goals. They were offered incentives for coming (food, art projects etc.) that demonstrates some understanding of what motivates and interests youth at this developmental stage. They set time aside at each session to discuss what had happened over the course of the week and to talk about the homework assignments, following up on the work participants were asked to do.

Year Program Established:

1988-1990.

Associated Studies:

Preventing Escalation in Problem Behaviours With High-Risk Young Adolescents: Immediate and 1-Year Outcomes. (1995); Dishion, Andrews.

Program Sponsors:

Staffing:

Oregon Social Learning Centre

Funding:

Grants from:

National Institute of Drug Abuse
U.S. Public Health Service
National Institute of Mental Health
Centre for Studies of Violent Behaviour and Traumatic Stress

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Creating Lasting Family Connections (CLFC)

Target Population:

CLFC was developed for use in universal, selective, and indicated populations and is currently in use throughout the United States with all three populations. The Creating Lasting Family Connections Implementation Training is designed to assist trainers to recognize how to adjust the implementation for effectiveness with selective and indicated populations.

Setting:

CLFC is designed to be implemented through any community system, such as churches, schools, recreation centers, and court-referred settings, which have significant contact with parents and youth, which have existing social outreach programs, and which have links with other human service providers. This program has been proven effective in urban, suburban, and rural communities, many of which have been multi-ethnic in composition.

Theoretical Basis:

The CLFC program is based on Risk and Resiliency Theory with an emphasis on strengthening the resiliency factors for youth, their families, and their communities. (For a complete description of the CLFC theoretical basis see pages 11-17, in Strader, T., Collins, D., & Noe, T. (2000). Building Healthy Individuals, Families, and Communities, Creating Lasting Connections. New York, NY: Kluwer Academic/Plenum Publishers.) This book is available through the developer.

Program Description:

Focus

Alcohol and other drug use and abuse, and violence prevention.

Goals

Training and early intervention will increase family resilience of parents and youth and the ATOD use and violence reduction results will be sustained through follow-up services. Use of alcohol and other drugs will be delayed or reduced by youths in the program group after individual youth, family, and community resilience increases following the training and early intervention program.

Objectives

Long-Term Objectives	Resiliency Factors Targeted	Intermediate Objectives	Intervention Components
Youth: • Delay onset of alcohol and other drug use • Reduce frequency of alcohol and other drug use • Reduce violence	**Community:** • Community engagement **Family:** • Parents' situational use of ATOD • Family meetings • Help-seeking for family problems • Positive communication with youth • Youth involvement in setting family rules • Positive consequences for youth following important family rules • Negative consequences for youth breaking important family rules • Family stability and cohesiveness **Youth:** • Youths' "getting real" communication • Youths' favorable attitudes toward ATOD use • Help-seeking • Youth bonding with parents • Youth bonding with community • Youth bonding with school • Youth school attendance **School:** • School climate	**Community:** • Successfully engage communities to implement CLFC • Communities successfully recruit and retain families • Communities sustain preventive efforts **Family:** • Increase appropriate situational use of ATOD • Increase frequency of family meetings • Increase help-seeking for family problems • Increase positive communication with youth • Increase youth involvement in setting family rules • Increase positive consequences for youth following important family rules • Increase negative consequences for youth breaking important family rules • Increase family stability and cohesiveness **Youth:** • Increase "getting real" communication • Decrease attitudes favorable toward ATOD use • Increase help-seeking • Increase bonding with parents • Increase bonding with community • Increase bonding with school • Improve school attendance **School:** • Improve school climate	**Community:** • Community Mobilization Component (CAT recruitment and development; CAT training) **Parent:** **Three Modules** • Developing Positive Parental Influences • Raising Resilient Youth • Getting Real Communication Training **Youth:** **Three Modules** • Developing a Positive Response • Developing Independence and Responsibility • Getting Real Communication Training **School:** • Any or all youth and/or parent modules (listed above) implemented in a school setting

Activities

Combination of: interactive instructional training and skill building for both parents and youth; encouragement to improve personal growth for both parents and youth; highly interactive social and refusal skills training for both parents and youth; highly interactive practice in communication skills for both parents and youth; social support for both parents and youth; desirable alternative activities are provided for both parents and youth.

Content

Family (parent/guardian) and Youth training:

The figure below illustrates the individual training components that make up the Creating Lasting Family Connections prevention program model. Prior to training, an optional CLFC Community Mobilization Module can increase recruitment and retention of parents and youth.

Youth Training	Parent Training
Developing a Positive Response	Developing Positive Parental Influences
↓	↓
Developing Independence and Responsibility	Raising Resilient Youth
↓	↓
Getting Real Communications Training	Getting Real Communications Training
↓	↓
(Optional) Getting Real: Parent and Youth Combined Sessions	

Each of the individual parent training sessions above is a 5-6 week module (2.5 hours a week.) Each of the individual youth training sessions a 5-6 week module (1.5 to 2 hours in length). The optional Parent and Youth Combined "Getting Real" sessions usually require an additional two or three (2.5 hours) meetings.

For maximum effectiveness, parents, and youth are engaged in all six modules consecutively and simultaneously. The CLFC program is designed with the following different implementation options:

- The modules (parent and youth) can be spread out for a longer period based on participant and provider needs. This can prove to be very beneficial because not all families are able to commit to a 15- to 18- week program. They can participate in 5-week increments spread throughout the period of a year.
- Parent training sessions can be offered without the youth training sessions (individually, consecutively, or collectively spread throughout the period of a year).
- Youth training sessions can be offered without the parent training sessions (individually, consecutively, or collectively spread throughout the period of a year).

Follow-up services:

- families can receive up to 5 consultations with a case manager for counselling and referral services if necessary;
- follow-up or case management services consist of telephone consultations or personal home visits for developing treatment or referral plans (as needed) and are provided for 6 months after the training.

Contact Time:

From as few as 5 sessions for any single module for up to 18 weeks for parents and youth for 2.5 hours per week.

Leader Type and Training Provided:

Completion of the *CLFC Assessment Survey* will help guide decisions about training needs. The assessment score provides a good measure of the amount and type of training needed by the potential trainers (results may also indicate that no training is necessary). Program publishers then discuss these scores with anyone who is considering training and negotiate a meaningful training plan by considering training needs, training budget, schedules, and agency commitment. A primary consideration is the experience level of those to be trained. Main training options are a Five Day Course for those with moderate levels of experience in prevention/facilitation and a Ten Day Training Course for potential trainers who are relatively new to prevention/facilitation. Contact publisher for more details on training options.

Intended Outcomes:

The evaluation assessed program effects on family and youth outcomes using repeated measures and random assignment of families to a program or comparison group in five church communities. Following is a summary of the published results:

Positive direct effects of the program (on family resiliency) included:

- Increased knowledge and healthy beliefs about alcohol and other drugs (AOD) by parents;
- Increased youth involvement in setting and following family AOD rules;
- Increased use of needed community services by families.

Positive direct effects of the program (on youth resiliency) included:

- Increased bonding with family members (parents);
- Increased leveling (honest and deep) communication;
- Increased use of community services by youth.

Positive moderating effects of the program on delay of onset and reduction in frequency of alcohol and other drug use by youth occurred:

As parents:

- Increased AOD knowledge and healthy beliefs;
- Decreased conflict between parents and children;
- Increased the likelihood of punishing youth for AOD use;
- Used more community services for family problems;
- Decreased family pathology;
- Decreased parents' frequency of alcohol use.

As youth:

- Increased leveling communication about AOD use;
- Increased bonding with father;
- Increased leveling communication about school work;
- Used more community services for family problems.

Other results include:

- 98% of parents and youth reported CLC to be a positive experience;
- 77% of parents reported feeling better about themselves after the program;
- 93% of youth reported feeling better about themselves after the program;
- 99% of parents would recommend the program to friends.

Publisher's Comments:

Through COPES' experience of facilitating the curricula, we have learned that specific trainer characteristics increase the likelihood of providing a successful training experience. The following is a list of characteristics we believe are helpful if one is to be an influential and effective trainer: 1) outgoing and caring personality; 2) nonjudgmental, tolerant of different opinions; 3) able to handle and accept ambiguity (can see both sides of an issue); 4) able to hold and model moderate beliefs and attitudes (does not hold or model extreme beliefs and attitudes); 5) possesses a natural helping attitude; 6) has experienced successful group oriented personal growth opportunities, including counselling, spiritual development, self-help, or related activities; and 7) able to recognize, name and express feelings as they occur.

Program Costs ($US)

It is difficult to determine the cost of implementation because agencies choose to implement this highly flexible, yet comprehensive program in such a variety of ways. There are six separate modules, three for parents and three for youth. These modules may be implemented

independently, in concert with other modules, or as a whole in a complete and full replication of the Creating Lasting Family Connections Program that includes all six modules and a Community Mobilization process. The following information may be helpful in determining implementation costs for a particular organization.

If the organization has skilled and experienced staff, then the only new cost may be the cost of the curriculum materials (from $1500 to $2000). However, most organizations typically need to budget at least $750 (per staff member needing training) for one week of CLFC implementation training, plus travel costs to a training site near them. If an organization (or a group of organizations) has several people who need training, the cost can be reduced. (Please call COPES, Inc. to examine a variety of training options.) Further, an agency might want to budget for as few as 2 part-time facilitators (for a medium to low fidelity replication) or for up to 4 or more part-time facilitators/trainers (for high fidelity implementation) in order to implement the entire program including mobilization, recruitment, and actual training. For example, let's say an agency wants to employ 4 part-time employees @ .10 FTE each in an area of the nation that an annual salary of $30,000/year is appropriate. The agency wants to serve 40-50 families per year. Therefore, this agency's first year costs might include the cost of materials (2 sets at $1,250.00 each = $2,500) + training (4 trainees x $750.00 = $3000.00) + part-time facilitators (4 x .10 FTE x $30,000 = $12,000) for a grand total of $17,500. (Note: Use your local rates for staffing including any cost for benefits and any travel costs.) This example includes, 4 part-time facilitators, and at this time commitment, they could serve 40 families per year, including recruitment and program services (but not evaluation). We've seen budgets ranging from as little as $10,000 to $12,000 per year serving 40 families and up to $250,000 serving 100 families per year. If an agency is serious about implementing the program as designed, the typical budget starts around $25,000 and up. Year two and subsequent years costs can drop considerably because training and related travel are not required. (In the future, as we gain evaluation data from these other sites regarding results, and then analyze these results in conjunction with budgetary investments, we hope to gain insight into the most appropriate levels of funding generally needed.)

Reviewer's Comments:

The developer has written a book that clearly describes the program, its design, theoretical basis, and results. (See associated studies.) Further, the book provides illustrative sample exercises for anyone interested in a quick overview of the CLFC program. Finally, the book includes a section on most frequently asked questions regarding the program. The developer will send all research articles and a full information packet to interested participants at no charge. Developer provides a very colorful and informative website for interested parties at http://www.copes.org.

In relation to prevention principles emphasized, the program: utilizes a comprehensive and systematic set of strategies encompassing many different models from resistance training, to information giving and role modeling by parents; developed unique and effective Community Mobilization Strategy for recruiting and retaining families; created a unique and effective flexible design for a great variety of implementation options suitable for a variety of settings;

incorporated life skills development for both parents and youth. All curriculum materials are well conceived, easy to use, and available at a reasonable cost. The developer will assist with custom implementation issues upon request. The developer will assist in grant writing/planning as available.

The program is designed to be flexible in order to create multicultural acceptance. A complete evaluation package has been created specifically for use with the CLFC program, and is available at a low cost.

Availability Information:

Resources Needed:

Curriculum 5 Training Manuals, set of 25 participant notebooks for all 5 trainings, and 5 poster sets, individual curriculum manuals.

Additional Materials include: CLFC Program Evaluation Kit, Trainer Assessment Survey, Fidelity Instrument, Additional Notebooks, Community Mobilization Manual, CLFC Implementation Manual.

Year Program Established:

Research Model, 1989 (CLC).

Diffusion Model, Creating Lasting Connections, 1998 (CLFC).

Associated Studies:

Strader, T., Collins, D., & Noe, T. (2000). Building Healthy Individuals, Families, and Communities, Creating Lasting Connections. New York, NY: Kluwer Academic/Plenum Publishers. (Creating Lasting Family Connections, (CLFC is the Dissemination Model).

Johnson, K., Strader, T., Berbaum, M., Bryant, D., Bucholtz, G., Collins, D., & Noe, T. (1996). Reducing alcohol and other drug use by strengthening community, family, and youth resiliency: An evaluation of the creating lasting connections program. Journal of Adolescent Research, 11(1): 36-67. (Creating Lasting Connections (CLC was the research, prototype model).

Strader, T., Collins, D., Noe, T., & Johnson, K. (1997). Mobilizing church communities for alcohol and other drug abuse prevention through the use of volunteer church advocate teams. The Journal of Volunteer Administration, 15(2): 16-29.

Johnson, K., Bryant, D.,Collins, D., Noe, T., Strader, T., & Berbaum, M. (1998). Preventing and reducing alcohol and other drug use among high-risk youth by increasing family resilience. Social Work, 43(4): 297-308.

Johnson, K., Noe, T., Collins, D., Strader, T., & Bucholtz, G. (2000). Mobilizing church communities to prevent alcohol and other drug abuse: A model strategy and its evaluation. Journal of Community Practice, 7(2): 1-27.

Program Sponsors:

Staff:

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Funding:

Funding for the original research project titled Creating Lasting Connections (CLC) was granted from CSAP (Center for Substance Abuse Prevention) High Risk Youth Grant (SPO 1279) from 1989 till 1995. The Creating Lasting Family Connections (CLFC) was created in 1998, and is self-sustaining.

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Families and Schools Together (FAST)

Target Population:

Selective or universal: 4-14-year old high-risk youth, who are identified by teachers or universal recruitment by classroom.

Setting:

Usually based in school, but always family focused, with multi-family groups, run by collaborative parent-professional trained teams with community representatives.

Program Description:

This program is based on a foundation of collaboration between the consumer parents, the elementary/or middle school, a substance abuse treatment community agency, and a mental health agency. Families and the parent-professional trained FAST team meet for 8 weeks in groups of 8 – 12 families; then for 2 years, the parent graduates lead the follow-up meetings.

The goals of the program are as follows:

- to enhance family functioning by strengthening the parent-child relationship and by empowering parents;
- to prevent the referred child from experiencing school failure by improving the child's performance and behaviour in school, involving parents in the educational process and increasing the family's affiliation with the school;
- to prevent substance abuse by children and the family by increasing knowledge and awareness of substance abuse and its impact in child development and by linking families to assessment and treatment services;
- to reduce stress experienced by parents and children in daily situations by developing informal support systems and linking with community resources and services.

The focus of the program is on building protective factors in seven relationship domains so as to:

- enhance the mother-child bond, the staff coach mother-child pairs as they spend 15 minutes of child-led "special play" at the multi-family groups. The pairs are observed and receive encouragement and suggestions. Their homework for the week is to conduct this "special play" every day.
- strengthen the parent to parent bond parents pair up in teams of two and listen for 15 minutes to a review of the "hassles of the day". This activity teaches them to listen to each other without judgement.
- increase the cohesiveness of the family unit, families engage in activities that are fun and make them laugh and connect with each other in a different way. These family-focused, parent led activities and family fun games help to strengthen their communication skills and increase their ability to solve problems. Parents are coached and supported in taking charge of their families.

- assist parents to form a parent self-help group by building informal support networks outside and within the members of the group. The difficult task of recruitment of isolated families is done by: home visits, putting concern for the child at the forefront, removing obstacles to participation, providing incentives and giving respite from the children. Parents want to get to know the parents of their children's friends at school, but are often too busy or shy to do so.
- ensure that staff help to foster and promote a positive parent school affiliation by helping parents to become more active in their child's school activities. Staff help parents to get to know them in another context by being involved in the program so that families build relationships with them.
- assist parents to community agency connections by building empowering formal networks. There is active participation by FAST graduates, self-help activities, assistance with barriers to service and discussions about ways to cope with life stresses. Professional staff attend all meetings and are perceived as people first.
- promote feelings of empowerment and a positive attitude in the parents. This is done by training the collaborative teams to be respectful of parents as the primary preventive agent for children; through providing outreach and home visits, positive attention and reinforcement of the parental role, offering support to the parents in many little ways, making personal achievement announcements, and the concept of reciprocity, offering parents a chance to give back to the program in some concrete way.

Contact Time:

Outreach home visits to recruit voluntary whole family participation; 8 weeks of multi-family group meetings 2 ½ hours each; 14 weeks of peer group meetings with 10 weeks of multi-family group meetings for middle school-aged youth; 2 years of monthly multi-family group meetings for program graduates organized by parents with staff and budget support; referral and family counselling as required in 2-year follow-up period; a total of 30 multi-family group sessions in 2 years, with home visits.

Theoretic Basis:

- family therapy and child psychiatry research;
- family stress and social support;
- community development and parent empowerment;
- social capital, reciprocal and trusting relationships;
- prevention and early intervention principles.

Leader Type and Training Provided:

Some aspects are led by trained staff, others by FAST parent graduates. Some elements are led by the parents in their own families (meals). Professionals attend and are resources to the families. The specifics of the training include building connections of the team members, review of program activities, research bases of activities, and the values of the parent respect and parent empowerment underlying FAST; there are also three site visits to adapt the program to local needs and directly observe the implementation and problem solve with the team; and a final day for review of FAST, and planning FASTWORKS with parent graduates.

Intended Outcomes:

A notable outcome of FAST is a high likelihood of retention: 80% of parents that attend once will complete the 8-week program. Families that never attend social functions, return to FAST across rural, inner city, suburban settings. These retention rates have held constant over hundreds of cycles in hundreds of communities.

The evaluation of the impact in the CSAP study was based on:

- the behaviours of the high-risk youth reported in the classroom and at home;
- the closeness or cohesiveness of the family;
- changes in parent behaviour, empowerment, social support and involvement in the child's school.

Results showed significant improvement on parent reports concerning conduct disorders, attention problems and total behaviour for the elementary school children. There was also improvement in attention problems, anxiety-withdrawal and psychotic behaviour in the middle school children. Teacher reports for elementary school children were significant on motor excess. Family cohesion increased and was maintained in the 2-year follow-up for elementary school children but not significantly for the middle school families. There is a strong correlation between the protective factors for strengthening and empowering families and involvement in their child's school. FASTWORKS, the follow-up support and network component run by parents serves the needs of some families and not others, so it was not heavily utilized in all cases. Some parents made dramatic changes in their lives and were transformed into active, social and contributing members of their community.

There were many issues with the evaluation and barriers to the smooth operation of the program and the study such as: professional collaboration, instrument selection, development of trust and understanding, maintaining trust and cooperation and a 40% attrition rate in the research sample which hampered the follow-up evaluation.

There were also some unexpected outcomes. The FAST parent graduates were as successful as professionally trained facilitators in bringing about quantitative reports of improvement in the behaviours of the at-risk children and cohesiveness in the families. The mothers of the children became empowered in other areas such as community leadership.

Program Costs:

FAST National Training and Evaluation Center, Directed by FAST program Founder Dr. Lynn McDonald; Costs for training a local site: $3900 not including travel and lodging for 5 visits; Costs for evaluating one local FAST cycle: $1000.

With widespread training, the challenge of quality assurance is a major concern. To this end, there is a systematic structure for FAST replication and dissemination that includes manuals, videotapes, trainer manuals, and lots of technical assistance.

Reviewer's Comments:

The focus of this program is on families, bonds between members and the role of the parents. So although it does not focus on the children in a direct way it does so indirectly by addressing a number of important risk and protective factors specific to the family and school environment. The nature of the activities that reinforce parent-child and family bonds and the building of formal and informal supports help to create sustainability and develop lifelong skills and networks.

Year Program Established:

- 1988-started in Madison Wisconsin, USA;
- 1990 became statewide initiative in Wisconsin under anti-Drug Legislation, for $1 million annually to be distributed competitively through state education division in three year grants to school districts. (now in 25% of Wisconsin school districts: 110 have done FAST);
- 1995 became statewide initiative in California;
- 1999 became statewide initiative in Missouri;
- 1999 became statewide initiative in South Carolina;
- 2000 became statewide initiative in NordRheinWestfalen Germany;
- 2000 became statewide initiative in North Carolina;
- Has been implemented in over 600 communities in 38 states in USA, 5 countries.

Associated Studies:

McDonald, L., Coe Bradish, D., Billingham, S. Dibble, N., & Rice, C. (1991). Families and Schools Together: An innovative substance abuse prevention program. Social Work in Education, 13(2) 118-130.

cDonald, L; Billingham, S., Conrad, T.; Morgan, A., Payton, E. (1997) Integrating strategies from mental health and community development: The FAST Program. Families in Society. 140-155.

McDonald, L and Sayger, T. (1998) Impact of a Family and School Based Prevention Program on Protective Factors for High Risk Youth: Issues in Evaluation. Drugs and Society.

McDonald, L. and Frey, H. (1999) Families and schools together: Building Relationships. Juvenile Justice Bulletin, NCJ 173423 Washington D.C. pp 1-20.

Investigators and Universities currently studying FAST program:

Dr. Tom Sayger: University of Memphis
Dr. Dan Flannery: Kent State University
Dr. Keith Warren: University of Miami
Dr. Tom Kratochwill: University of Wisconsin
Dr. Paul Moberg: same
Dr. Lynn McDonald: same
Dr. Phil Leaf: Johns Hopkins University
Dr. Tony Bryck: University of Chicago

Program Sponsors:

Staffing:

FAST is a collaborative program pulling a team from across systems. Each FAST program must be implemented by a core team made up of representatives of the child's community; the team must culturally, ethnically, racially and with language, be representative of the consumer families:

- Elementary school: parent, school, two community agencies (substance abuse, mental health);
- Middle School: add youth representative, adult youth advocate.

Funding:

Funding for FAST has come from many sources, including local, state, and federal, and including public and private funds:

- A CSAP High Risk Youth Grant (Center for Substance Abuse Prevention);
- United Way of Dane County (initial implementation);
- Wisconsin Department of Health and Human Services (initial implementation);
- Foundations;
- Child abuse and neglect prevention;
- Delinquency Prevention;
- Parent involvement in schools;
- Family support;
- Research and Development funds have come from CSAP, NIDA, ONDCP, CMHS, SAMHSA, OJJDP, ACYF, OHD, OERI, and OSERS.

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Motivational Interviewing

(Conducted in the Emergency Room)

Target Population:

Selective; 94 adolescents 16 – 19 years of age treated in an emergency room following an alcohol-related event.

Setting:

Emergency room of the hospital following treatment for an alcohol-related event.

Theoretic Basis:

- motivational interviewing;
- harm reduction.

Program Description:

Focus

Harm reduction in alcohol use.

Goal/Objectives

To reduce the harm associated with drinking among alcohol-positive adolescents in an ER.

Activities

Brief motivational interview.

Content

- combines personal feedback regarding drinking patterns and effects with an empathetic style and self-efficacy enhancement;
- focus on empathy, no arguing, developing discrepancy, self-efficacy and personal choice.
- Five sections:
- introduction and review of event circumstances;
- exploration of motivation (pros and cons);
- personalized and computerized assessment feedback;
- imagining the future;
- establishing goals.

Handouts were given as well as an information sheet about the effects of alcohol on driving and a personalized feedback sheet.

Contact Time:

A 35 to 40-minute interview; patients were re-interviewed at 3 and 6 months.

Leader Type and Training Provided:

Twelve bachelor to master's level staff members with 1–2 years of experience; they completed extensive MI training; weekly group supervision was provided.

Intended Outcomes:

The intervention was acceptable and feasible to the staff. Those who received the intervention were:

- less likely to report having driven after drinking than those who received standard care;
- less likely to report having an alcohol-related injury or to have alcohol-related problems;
- less likely to have a moving violation according to DMV records.

Six months after their ER visit, the motivational interview group showed a 32% decrease in drinking and driving and had half the occurrence of alcohol-related injuries.

Author's Comments:

- the intervention takes advantage of a "teachable moment" following an alcohol-related event and possible injury;
- all patients showed a significant reduction in their drinking during the follow-up;
- it is possible that having an injury that required treatment in the ER could account for this significant reduction;
- reaction to assessment may account for the lack of group differences in alcohol use;
- the utility of the interview was in producing harm-reduction effects rather than reduced alcohol use;
- perhaps a more intense intervention that included booster sessions would have an effect of differential drinking;
- need to be cautious about generalizing as other age groups or those with more severe drinking problems may not react as well.

Reviewer's Comments:

The intervention is simple, brief and seems to have a significant effect on the reduction of harmful behaviours of the patients that received it. A longer follow-up period would be of interest.

In terms of prevention principles emphasized: the intervention's intensity and duration were appropriate and respectful of the patients situation and the time available by staff for the intervention; the goals are clearly harm reduction; they take advantage of a "teachable moment"; the intervention looks at motivations and helps the patients examine their actions and their consequences in a supportive way; the actual content of the interview is individualized to the situation and varied accordingly; the interventionists were well educated, intensively trained and well supervised and monitored.

Associated Studies:

Brief Intervention for Harm Reduction with Alcohol-Positive Older Adolescents in a Hospital Emergency Department. (1999); Monti, Spirito, Myers, Colby, Barnett, Rohsenow, Woolard , Lewander.

Program Sponsors:

Staff:

Veterans Affairs Medical Centre, Providence
Brown University
Rhode Island Hospital
Veterans Affairs Healthcare System, San Diego
University of California, San Diego

Funding:

Grant from the National Institute on Alcohol Abuse and Alcoholism
Department of VA Career Scientist Award
VA Merit Review grant from the Medical Research Office of Research and Development

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Community Partnership Program

Target Population:

Universal; adults, 10th Graders, 8th Graders.

Setting:

Community settings.

Theoretic Basis:

Most communities used community change models.

Program Description:

The main purpose of the program was to decrease substance abuse by improving conditions in the community environment.

The program did not dictate to the communities what their strategies should be. Instead they were to come up with their own plan when they applied for the grant. There were some conditions attached; the grants were for 5 years ($ 350,000 per year), the mandate was to carry out long-range, comprehensive substance abuse prevention programs, already existing programs had to be coordinated and leveraged, at least 7 local agencies, including government, had to be at the table and a large number of volunteers had to be mobilized for the coalition activities.

Examples of partnership activities and actions include: awareness activities (fundraisers, festivals), program activities (training programs, workplace programs, media campaigns) and local policies and regulations (smoking by-laws, drug-free school zones). Strategies varied according to the type of community (i.e. resource rich, surrounded by illicit drug activities).

Contact Time:

5-year funding; evaluation was over a period of 18 months.

Leader Type and Training Provided:

- most communities were led by a coalition of agencies and services.

Intended Outcomes:

- community partnerships are a viable strategy for preventing substance abuse;
- statistically significant reductions occurred in regular substance use by males but not females;
- for adults who reduced their use, four factors were important: living in the community with the partnership program, being involved in the activities, living in a neighbourhood perceived to have minimal illicit drug trading or market and having a disapproving attitude toward the use of illicit drugs;
- 8/24 of the matched communities showed some significant reduction in substance use;
- 5/8 successful communities used all of the desirable strategies outlined above, and came from diverse communities;

- barriers in some communities included: misunderstanding of the basic ground rules, limiting the membership, allowing staff too much control relative to the partners, and overlapping identities between the partnership and some of the agency members;
- over the course of 5 years most communities altered and adapted their 5-year plan in order to accomplish their goals;
- the role of the staff was to serve as catalysts;
- all member agencies signed a written contract.

Author's Comments:

Communities need to work together to form partnerships to reduce drug and alcohol abuse – a strategy that is more effective than traditional fragmented approaches; more activities and prevention strategies need to be aimed at girls, many of the preventive efforts and activities appealed more to the male population.

Reviewer's Comment:

In the communities with the most impressive outcomes a number of desirable strategies emerged. They had a comprehensive vision covering all aspects and players in the community. This vision was shared and agreed upon by groups and citizens across the community. They had a strong core of committed partners from the beginning with a membership that was inclusive and broad-based. Misinterpretations of the partnership's basic purpose were resolved or avoided. The partners understood that their real goal was that they all must contribute to the well-being of the partnership. Decentralized units worked at the local neighbourhood level. There was not an excessive amount of staff turnover. They developed extensive preventive activities and got support for institutional and local policy change. A "fiscal agent" was designated and responsible for handling the money although the distribution of the money was a group decision. The prevailing attitude of the successful coalitions was to see this as a long-lived entity not a special project.

Year Program Established:

1990 – 1995.

Associated Studies:

Prevention Works Through Community Partnerships. Substance Abuse and Mental Health Services Administration. (2000); Yin et al.

Program Sponsors:

Funding:

Grants authorized under the Anti-drug Abuse Act of 1988

Contact:

Robert Yin
Project Director
COSMOS Corp.

The Heroic Journey: Ancient and Modern Stories to Grow by

(Culturally focused intervention of the Life Skills Training Program)

Target Population:

Universal; inner-city, minority, public school youth, Grade 7, New York City for the life skills program. Selective; high-risk students for the culturally focused intervention.

Setting:

- life skills training: inner-city public school classrooms;
- culturally focused intervention: group counselling.

Theoretic Basis:

- cognitive-behavioural prevention approach;
- theory of reasoned action;
- social learning theory.

Program Description:

Focus

Alcohol and illicit drug use.

Goals

Provide adolescents with the requisite knowledge and skills for resisting social influences to use alcohol and drugs as well as to reduce potential motivations to use alcohol and drugs by increasing general personal competence.

Objectives

Address the major cognitive, attitudinal, psychological, and social factors that are either empirically or conceptually related to alcohol and drug use.

Activities

Life skills training and culturally focused training used a combination of demonstration, behavioural rehearsal, feedback and reinforcement.

The mediums of live story-telling, video and peer leaders were used to tell the mythic and contemporary tales in the culturally focused program.

Content

Each of the 15 sessions for each group consisted of a major goal for the unit, measurable student objectives and classroom activities.

Both taught students cognitive-behavioural skills for problem solving and decision-making, building self esteem, resisting peer pressure, managing stress and anxiety, communicating effectively, and developing positive personal relationships.

Life skills training also taught knowledge related to drugs and alcohol, the culturally focused program did not.

The culturally focused curriculum focus was on preferences, socio-demographic features and interpersonal characteristics of high-risk youth. The material was taught using stories in teaching the skills and demonstrating the positive consequences of using the skill through the story structure. The students saw the functionality and meaning of the skill enhancing the observational learning process.

Contact Time:

Fifteen sessions at an average of two per week.

Leader Type and Training Provided:

Outside intervention leaders were hired and trained to provide the 15-session life skill intervention training. Additional trainers were hired for the culturally specific program.

Peer leaders were selected by the school system and given a weekend workshop that provided an overview of the curriculum. They also had bi-weekly practice sessions to practice the role-playing during the semester.

In the culturally focused program, a professional storyteller accompanied by music was used to relate the ancient stories at student assemblies.

Videos were used to tell the contemporary stories and peer leaders demonstrated scenes from the videos that taught each of the skills.

Intended Outcomes:

- the prevalence of current alcohol and drug use among minority adolescents before the implementation of the interventions was relatively low, therefore the focus was on future behavioural intentions for alcohol and drug use;
- the findings were primarily related to intention to drink beer or wine, drink hard liquor, or use other drugs in the future;
- both interventions were equally effective in decreasing intentions to drink beer or wine in the future;
- the broad spectrum life skills approach reduced future intentions to use hard liquor and illicit drugs;
- the cultural approach helped lower intentions to drink hard liquor;
- several mediating variables were affected, the students in the prevention programs had significantly higher anti-drinking, anti-marijuana, anti-cocaine and other anti-drug attitudes than the control groups;
- the risk-taking scores for the intervention were lower than those in the control group;
- the study did not demonstrate efficacy on the skills measures for either intervention group compared with the controls.

Author's Comments:

Self-report of skills may be difficult for students of this age group; the measures may not have corresponded well to the components of the curricula; exposure to prevention programs may provide a protective factor related to the future initiation of alcohol and drug use; limitations are the relatively small group of students and the inability to determine the relative effectiveness of these preventive strategies for the various ethnic-racial subgroups in the sample.

Reviewer's Comments:

The techniques used in the culturally focused group were very creative and seemed to be as effective as the broad spectrum program, which then begs the question: would the broad spectrum program have worked as well with the cultural group as did the program designed especially for them and why couldn't the broad based program incorporate some of the creative, story-telling techniques.

The program did appear to address some protective factors and recognized that a different approach may be more effective for minority youth; had a focus on skill development; the program was interactive; the cultural component especially used interesting and engaging techniques; the program was extensive and covered a significant period of time; and the leaders were trained and hired specifically for their skills.

Associated Studies:

Alcohol and Drug Abuse Prevention Among Minority Youths (1994); Botvin, Schinke, Epstein, Diaz.

Program Sponsors:

Staff:

Institute for Prevention Research, Cornell University Medical College
New York State Division of Substance Abuse Services

Financial:

Supported by funds from the New York State Division of Substance Abuse Services.

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Focus on Families

Setting:

Families.

Target Population:

Indicated; Focus on Families is most appropriate for parents enrolled in methadone treatment with children between the ages of 3 and 14 years. Parents are encouraged to have at least 90 days of methadone treatment prior to beginning the program.

Theoretic Basis:

Focus on Families uses the social development model to address risk and protective factors for teenage drug abuse and for parent's post-treatment relapse. The social development model is an integration of social control theory and social learning theory. Like social control theory (Hirschi, 1969), the model views bonding to others as a critical influence on social behaviour. The model incorporates processes specified in social learning theory (Akers, 1977) to explain conditions under which bonding develops and the direction (prosocial or antisocial) of behavioural influences of bonding.

Program Description

Children of addicted parents are generally exposed to multiple risk factors within their families. There is evidence to suggest that risk increases exponentially with exposure to multiple factors (Newcomb et al. 1987; Rutter, 1980). The evidence also suggests the importance of the family in the etiology of adolescent drug abuse. If one accepts the premise that effective prevention entails intervening to eliminate or protect factors implicated in the causal process, there is reason to expect that interventions targeting parents who are in methadone treatment can effectively reduce future drug abuse by their children.

Focus on Families seeks to assist parents in learning family management skills to reduce risks in their families that could contribute to children's future drug abuse by strengthening and clarifying family expectations for behaviour, and enhancing conditions that promote bonding in the family. Focus on Families recruits participants through the methadone clinic. Eligible families participate in a 5-hour "family retreat" where families learn about the curriculum, identify their goals, and participate together in trust building activities. This first session is followed by 32 curriculum sessions. Sessions are conducted twice a week over a 16-week period. Parent sessions are conducted in the morning. Twelve practice sessions are offered in the evening for children to attend so that parents can practice developmentally appropriate skills with their children. Parent sessions are conducted with groups of six to eight families co-led by two Master's level therapists. Follow-up home-based case management is provided to all families involved in the parent training program by Master's level therapists.

The Focus on Families intervention uses several incentives to address the anticipated problems with recruitment and retention. During the research study, monetary reinforcers were given for session attendance ($3) and completion of homework assignments ($2), and transportation and

childcare at sessions were provided as needed. Food was provided at all sessions. Children received small toys for their participation, and a variety of other family incentives were offered, such as tickets to the zoo, aquarium, and baseball games, which were donated by respective organizations.

Content

Each grouping of sessions follows a similar format and includes the following: practice exercises, involvement activities, developmental issues appropriate to the topic, family meeting activities, relapse issues, and motivation to use the skills. Specific content covered includes:

- **Family goal setting.** A 5-hour kick-off retreat focuses on goal-setting and bringing families together to share a common trust-building experience. This session empowers families to work together to develop goals for their participation in the family sessions. Case managers later work with individual families to identify the small steps they need to take in order to reach their identified goals. (One session, children attend).
- **Relapse prevention.** These four sessions include (a) identification of relapse signals or triggers, (b) anger and stress control, and (c) creating and practicing a plan to follow in case a relapse occurs. The impact of relapse on the client's children is emphasized, and skills are taught to prevent and cope with relapse and relapse-inducing situations (Marlatt & Gordon, 1985). Parents are taught to identify the cognitive, behavioural, and situational antecedents (signals) of relapse, and to use self-talk to anticipate the consequences of their drug-using behaviour (Hawkins et al., 1986). (Four sessions, children do not attend).
- **Family communication skills.** Parents are introduced to the joys of playing with their children during these sessions. The skills of paraphrasing, asking open-ended questions, and "I" messages are taught during these sessions. In addition, parents explore developmentally appropriate parenting practices. Families practice using the skills during two practice sessions. All subsequent groups reinforce the use of the communication skills taught in these early sessions. Families then use these skills to develop family expectations, conduct regular family meetings, and make family play and fun time successful. (Five total sessions, children attend two guided practice sessions).
- **Family management skills.** Parents learn and practice setting clear and specific expectations, monitoring behaviours, rewarding positive behaviour, and providing appropriate consequences for negative behaviour. Parents practice implementing "the law of least intervention," that is, using the smallest intervention to get the desired behaviour from their child. A variety of discipline skills learned and practiced by parents include praise, ignoring, expressing feelings, using "if-then" messages, time-outs, and privilege restrictions. The advantages and disadvantages of using spanking as a discipline technique are discussed and parents review tips for reducing spanking. Parents chart both their own behaviour (for consistency) and their children's behaviour to aid in recognizing and reinforcing the desired behaviours. Parents are referred to outside resources for children's behavioural problems, if needed. (Eight total sessions, children attend two guided practice sessions).

- **Creating family expectations about drugs and alcohol.** Families work together to define and clarify expectations about drug and alcohol use in their families. Parents are taught how to involve their children in creating clear and specific expectations, monitor, and provide appropriate consequences for violations of the expectations. Families work together to establish written family policies for tobacco, alcohol, and other drug use. (Three total sessions, children attend two guided practice sessions).
- **Teaching children skills.** Parents learn how to teach their children two important types of skills, refusal skills and problem-solving skills. Parents teach and practice the skills with their children during sessions so that trainers can guide parent teaching practices. Teaching skills provides parents with additional reinforcement of techniques for avoiding relapse. (Seven total sessions, children attend three guided practice sessions).
- **Helping children succeed in school.** Parents build on the previously learned skills to create, monitor and provide appropriate consequences in a home-learning routine for their children. Parents identify times, places, and rewards for homework completion. Strategies to assist children with homework are taught and practiced. Parents review communication skills and practice using the skills to communicate with school personnel. The group sessions end with a family "graduation" ceremony and potluck event. (Five sessions, children attend two guided practice sessions).

Activities/Process

Given the severity of these parents' dysfunction it is necessary to provide practice opportunities as well as skill components that address specific recurring problem behaviours. The parent training format combines a peer support and skill training model. The training curriculum teaches skills using "guided participant modeling" (Rosenthal and Bandura, 1978) in which skills are modeled by trainers and other group members, discussed by participants, and then practiced. Videotape is frequently used in modeling the skills or giving feedback after skill practice. To maximize effectiveness, the training focuses on affective and cognitive as well as behavioural aspects of performance (W. T. Grant Consortium on Social Competence, 1992).

The curriculum allows participants to practice in situations they currently face with their own children. Parents complete home extension exercises after each session to generalize the skills from the training setting to the home setting. After parents learn and practice skills, parents and children practice using their new skills together in family sessions with their home-based services case manager.

Follow-up:

Following their graduation from the parent-training group, families are invited to a monthly potluck. The potluck acts as a booster session for families and helps them maintain behaviour changes learned in parent training sessions. At each potluck, families review their progress toward their goals, go over skill steps, and discuss their use of skills at home. Activities include: reviewing the skills learned in combined sessions; identifying supportive and problem people in their social network; progress in school/home learning

environments; reviewing rewards by making reward jars; reviewing the law of least intervention; making charts for specific behaviours that need to be addressed in the family; reviewing problem solving steps, paraphrasing, open questions, expressing feelings, refusal and anger control skills.

Case Management System:

In addition to the parenting curriculum, the program includes home-based case management to help parents and children generalize and maintain the skills learned in the group sessions. These home-based services are provided to families for about 9 months, beginning 1 month before the start of the parent training sessions and continuing through the group training period (4 months) and 4 months afterward. Case managers help families identify goals, monitor progress toward these goals, and reinforce in the home skills parents learned in class. They help families hold family meetings, increase each member's opportunities for family involvement, and promote children's opportunities for involvement in positive activities outside of the family. Case managers also work with parents to reduce their risk for relapse through reinforcing training in relapse prevention and coping skills, assisting parents to be productively engaged in school or employment, and building a supportive and drug-free personal network for parents. They help secure community services for families as needed. Case managers attempt to have one home visit (about 90 minutes' duration) and two phone calls per week. Thus, during the parent training phase, each family receives up to 5 hours of direct service per week, including 3 hours of group sessions and 2 hours of case.

Intended Outcomes:

Parents in the experimental and control groups were compared on self-report measures of problem-solving skills, self-efficacy, social support, family factors, and frequency and consequences of drug use. Children in the experimental and control groups were compared on self-report measures of child drug use and other problem behaviour, school performance, association with delinquent peers, and family bonding, structure, and management.

To examine outcomes, analysis of covariance techniques were used to assess experimental and control group differences at immediate post-intervention, 6 months following the intervention, and 12 months following the intervention, controlling for baseline measures. For analyses of children's outcomes, age was added as a control, and the interaction between experimental assignment, age, and each outcome variable was examined to test whether the effectiveness of the intervention was contingent on the age of the child. Due to the use of developmentally appropriate measurement instruments for children, baseline data were limited for younger children. In analyses testing for the interaction between age and experimental assignment, baseline covariates were excluded in order to maximize the number of cases and the age range of the children examined.

Parent Outcomes-Differences between experimentals and controls consistently favored the experimental group. Parents were assessed using the PSI (Problem Solving Inventory), an audio-tape role-play test. Parents were asked how they would respond to various types of

problem situations and how likely they would be to use drugs in each situation. Experimental parents at all time points for all skill measures had significantly higher scores than control group parents and displayed greater self-efficacy (i.e., reported that they would use drugs in these situations less frequently) than control parents at each of the three follow-up time points.

Few differences between experimental and control parents were found in parent reports of family involvement, management, conflict, or bonding until later follow-up periods. However, at the 6-month follow-up there were small differences in the number of family meetings favoring experimental families. At the 12-month follow-up, experimental families had significantly less domestic conflict and had established more household rules than control families.

At the 6-month follow-up, experimental subjects reported greater availability of social supports, greater personal network attachment, and slightly less association with deviant peers than control subjects, although these differences were not significant. At the 12 month follow-up, there was a trend level difference indicating that experimental parents had fewer deviant peers than controls.

Overall, experimental parents had less drug use than control parents. Experimental parents used significantly less heroin at the end of parent training and 12-month follow-up and less cocaine at the 12- month follow-up than control parents. Experimental and control parents displayed similar levels of marijuana use during the evaluation period. Biochemical measures to assess veracity of self-reports of drug use were employed with a random sample of subjects at each time period and no experimental-control differences in veracity were discovered.

Child outcomes-There were few significant main effects of the intervention. Nineteen measures at two time points were examined and only four significant differences at the .05 level were found.

In the family domain, differences appeared to favor the control group. At the 6-month follow-up the control children were more likely to report that their parents used denying privileges as a form of discipline. At 12 months these differences remained but were no longer significant. At 12 months the global scale of parental recognition favored the control group at the .10 level. It also appears that experimental children were more likely to become separated from their parents. Experimental children were significantly less likely to live with a father figure at 6 months and with the FOF parent at 12 months.

Three 'age by experimental condition' interaction effects were found to be significant at the .05 level. Each of the three indicates that the less frequent involvement of experimental children with their parents occurred only among the older children. At the 6-month follow-up, older experimental children were found to be less unlikely to live with a father figure (odds ratio = 0.83, $p < .05$, $n = 114$) or live with their FOF parent (odds ratio = 0.53, $p < .05$, $n = 114$), while no such differences were found among the younger children. Also, at the 6-month follow-up an age by experimental condition interaction effect on the activities involvement index reflected that older experimental children reported engaging in fewer activities with their parents than older control children did, while among the younger children, the experimental children reported significantly more involvement in activities with their parents compared to younger control children (change in $F = 5.50$, $p < .05$, $n = 94$).

Although no statistically significant differences between experimental and control children were found in the areas of drug use or delinquency, the direction of differences favored the experimental group in all but one of the comparisons made in these two areas. Secondary analysis of individual items in the delinquency scale revealed that children in the experimental group were less likely than controls to have reported stealing in the six months prior to the 6-month interview (26% vs. 10%, odds ratio = 0.31, $\underline{p} < .10$, $\underline{n} = 77$).

Program Costs:

Three sets of implementation materials have been created:

- A curriculum manual that includes the key content and process objectives for each of the 32 sessions and the family retreat. A large illustrated color map provides families with a sense of direction and focus for the curriculum. Each unit has a corresponding stop-point. For example, checkpoint choice refers to the family retreat, communication bridge refers to the communication skills sessions and so on;
- The Focus on Families workbooks provides weekly supplements and home practice exercises that families add to a notebook to create a manual;
- A case management procedures manual provides record keeping forms and strategies for home-based services;
- Language: English only;
- Readability: 8th Grade or below;
- Current Use: The curriculum has been sold internationally (Spain, Australia, Canada, U.S.). The curriculum is still being conducted at Therapeutic Health Services in Seattle, WA.
- To order curriculum materials: Contact Tanya Witters, Social Development Research Group, University of Washington, 9725 3rd Ave NE, Seattle, WA 98115, (206) 685-1997 Fax 206-543-5407 Cost: $200 for the curriculum and workbook package of materials, pre-pay only, allow 3-4 weeks for delivery;
- For training: Contact Therapeutic Health Services Training Institute. 206-323-0930.

A two person training/case management team is needed to implement the program. It is recommended that persons be familiar with addiction, methadone treatment, and parenting practices. A formal training program is not required but is recommended for implementation fidelity. Training will be made available through the Social Development Research Group.

Focus on Families can be implemented by purchasing the curriculum and case management materials. Though the program effects have not been tested separately, it is possible to implement the parenting curriculum without the home-based service. Cost for conducting the parent training only would be about $5000. The total cost per family for full 9-month preventive intervention including 33 sessions of the curriculum and home visits is about $3, 000.

Reviewer's Comments:

In terms of prevention principles emphasized, this program went out of its way to tailor a social development strategy to the special needs of opiate addicted parents in treatment. As a result the duration and intensity is twice as long as other universal and selected programs of this nature. The home-based component provides: added intensity, a means of retaining the participants and an opportunity to monitor their progress and keep them on track.

The program leaders are very well educated, experienced and trained, which constitutes another requirement of working with this group of parents.

Two Master's level therapists conducted the parenting sessions and two other Master's level therapists conducted the home-based case management services with families in the research study. Currently, two case managers conduct the parenting sessions and provide home-based services to a caseload of about eight families.

Associated Studies:

Kevin P. Haggerty, Elizabeth Mills, and Richard F. Catalano (1993).

Program Sponsors:

Social Development Research Group, University of Washington, funded by the National Institute on Drug Abuse. Training available through Therapeutic Health Services Training Institute, Seattle, WA.

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AIDS Education for Male Adolescents in Jail

(Part of the Rikers Health Advocacy Program [RHAP])

Target Population:

Selected; incarcerated male adolescent drug users. [16-19 years of age].

Setting:

Community – New York City's main jail facility.

Theoretic Basis:

Problem-solving therapy.

Program Description:

The sessions focused on issues relevant to the target group with emphasis on HIV. The male counsellor used written curriculum to cover general health topics; factors leading to the initiation and continuance of drug use; the social, economic and health effects of drug abuse; and the consequences of risky sexual behaviour.

Participants were compensated $10 for the baseline review and $5 for each educational session attended (deposited in their commissary accounts). The facilitator guided the discussion. Members participated in a work group environment by sharing facts and beliefs, defining high-risk attitudes, suggesting possible courses of action, and critiquing alternative solutions.

Contact Time:

A voluntary, four session (two sessions per week) one hour small group intervention.

Leader Type and Training Provided:

Adult group facilitator with counselling experience, trained by senior staff.

Intended Outcomes:

Self-reports indicated an increased positive attitude toward condoms and increased condom use. Levels or types of drug use were not affected by the intervention.

Author's Comments:

The program curriculum and user's guide are available for sale from Sociometrics Corporation at www.socio.com.

Reviewer's Comments:

This intervention attempted to change behaviour in a group of individuals that exhibit high-risk attitudes. While they had a good response to the program, the youths were compensated for their participation (although the compensation should not have affected their interest in the session or the reported outcomes). The change in behaviour may not have been as great as the author's might have expected. The authors cite that a longer session may have more impact on the youth's modifying their behaviour, although the youth appear to personalize the threat of spreading HIV/AIDS as a problem for other groups.

This is a very vulnerable population and the author's suggest that there may need to be more opportunities for integrating the high-risk youth back into conventional society, otherwise their sexual and drug behaviours will continue to put them at risk.

The program was established to meet the unique needs of this population, combining decision making with general information on how to reduce the harms associated with certain high-risk behaviours. Organizers were able to create an environment were trained counselors developed an interactive program and through group participation foster action plans and critical solutions.

Year Program Established:

February 1991-February 1992.

Associated Studies:

Outcomes of Intensive AIDS Education for Male Adolescent Drug Users in Jail (1994); Magura, Kang, Shapiro. Journal of adolescent health 15: 457-463.

Program Sponsors:

Funded by the Grant #R01DA05942 from the National Institute on Drug Abuse.

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AIDS Evaluation of Street Outreach Project (AESOP)

Target Population:

Selective:

The homeless, runaway street youth in San Francisco who exhibit high-risk behaviour in injection drug use and risky sexual activity.

Setting:

Street, a defined six block area within a community.

Theoretic Basis:

Behavioural theory.

Program Description:

The first phase of the project was to have outreach workers go out into the community, provide condoms, bleach and information to street clients. A storefront centre later provided a place where more in-depth dialogue could take place on STD, drug problems and other concerns. Later more materials were developed based on this unique local youth sub culture. Focus groups representing the local youth, as well as the direct involvement of the youth were used to create information material and media, and activities for their peers. This resulted in specific designs for posters, t-shirts, condom packets, and a video on prevention.

The challenge of the intervention was to develop material specific to the different groups within the community. There were those [deadheads] who would respond to messages about protecting your family members through safe behaviour. In contrast, there was a culture in the area [punk/squatter] that responded to messages directed at protecting yourself or on survival. In addition to providing information and support the centre offered free meals and showers.

Although not directly related to the operation of the centre, there was also a youth needle exchange operating in the area, which informally shared information about what services were available in the community.

Contact Time:

As required by the client.

Leader Type and Training Provided:

Professional outreach workers, peers.

Intended Outcomes:

The evaluation of the intervention examined longitudinal changes in the high-risk youth's behaviour in injecting and in their sexual practices.

Focused sub-culture specific interventions were successful in reaching this hidden population, the high-risk street youth. This was shown through an increase in the frequency of contact with the outreach worker and the number of referrals, as well as an increased likelihood of using a new syringe at last injection.

The evaluation also suggests that the peer recruitment was successful in locating and enrolling the youth. One finding was that the follow-up on referrals by youth to programs that did not appear to have the same sub-cultural influence were not well attended by the youth.

The development of the needle exchange program did increase the use of clean needles; where this was only noted with a very high level of contact with the outreach worker. The results also showed the introduction of needle exchange did not have an impact on other referrals, which suggests that needle exchange can influence the youths IDU behaviour, but cannot replace other outreach interventions.

Reviewer's Comments:

During the evaluation of this intervention, there were limitations noted that may have impacted on the results. There were population shifts by the street youth, increased police enforcement and unusually severe weather patterns that may have hampered the youth in accessing the outreach services. In spite of these cautions, the authors indicate that the sub-cultural intervention did result in increased participation in the high-risk reduction activities, however there did not appear to be any impact on sexual behaviour.

In their conclusions the authors indicate that further research was warranted in the areas of: following cohorts of youth; using more sensitive measures of risk behaviour; and developing more preventive initiatives for this high-risk youth population.

In terms of best practices, the program presented a strong framework through its integration with core activities of relevant organizations in the community. The program considered the values, language and culture of young people by having the youth participate in the development and outreach of information materials. Also, youth were not viewed as a homogenous group, as subcultures were identified in an attempt to provide tailored, relevant services.

Associated Studies:

The Impact of Intensive Outreach on HIV Prevention Activities of Homeless, Runaway, and Street Youth in San Francisco: the AIDS Evaluation of Street Outreach Project (AESOP) (1997); Gleghorn, Clements, Marx, Vittingoff, Lee-Chu, Katz.

Program Sponsors:

Support:

Centres for Disease Control and Prevention

Study:

Haight-Ahbury Youth Out-reach Team
San Francisco Department of Public Health-AIDS Office

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Clean Needles Now [CNN]

Target Population:

Selective; young runaway, homeless, and other street injection drug users who frequent the Hollywood area of Los Angeles. Included are the sexual partners of the IDUs and other high-risk drug using youth.

Setting:

Street, defined community.

Theoretic Basis:

The initial treatment was based on the Disease Model of intervention and shifted towards a more acceptable Harm Reduction to change behaviour.

Program Description:

The primary goal of the program is engagement. Once the relationship is begun they assist in building confidence, self-esteem and assist the clients in gaining control over their lives to get off the street.

Using peer workers, the clients are encouraged to seek services from a store front facility located in the area. The centre operates as a drop in and includes:

- Adolescent needle exchange: needles are available either for exchange or for distribution;
- Safe shooting kits and information: they provide kits [bleach, distilled water, tourniquets, etc.] and information by and for the IDU;
- Creative art: Alternative Highs is an art and event program provided as an alternative to substance use;
- Substance use counseling: substance abuse and mental health services counsel in life skills training, self-management and relapse prevention;
- Case management: peer caseworkers link to other referring agencies and/or services. (i.e. food, shelter, employment).

Contact Time:

As needs dictate.

Leader Type and Training Provided:

Professional workers; Peer workers.

Intended Outcomes:

An evaluation of the program has shown that in order to maximize the contact with the street youth you have to offer services that meet their immediate needs. Once you build the initial trust it is easier to get them further involved in other harm reduction activities such as safer injection techniques, health care, shelter and ultimately drug and alcohol treatment.

Three times the clients engaged in needle exchange by comparison to the other services. Over time the clients began contacting the peer workers and access to other services increased. The IDU youth emphasized how important the safety of the site was to their participation.

Reviewer's Comments:

The success of this program appears to have been achieved through the change from the disease model of intervention with the youth to harm reduction. The inclusion of peer workers assisted in the development of the trust between the clients and the agency, with the outcome that the high-risk youth began to modify their behaviour and seek referrals to other agencies for help.

Albeit the evaluation of this program focused qualitatively on the program, it appears that its operating principles [harm reduction] and the use of peer workers was successful in attracting this illusive population to their facility. Even though their success was not quantified, it did show that this collaboration between service provider and the drug using youth community to define needs and services, can have a positive effect on modifying drug using behaviour.

This program exemplified a number of best practices. The program provided a comprehensive framework through a continuum of prevention and harm reduction approaches, which addressed the environment in which unsafe behaviour occurs. After realizing that the goal of abstinence was unattainable, the program began focusing on a more realistic and attainable goal, to reduce the harms associated with this special population's injection drug use. Finally, they increased the credibility of the program by utilizing peers, thereby increasing participation rates.

Year Program Established:

1993.

Associated Studies:

A Collaborative Evaluation of Needle Exchange Program for Youth. (1999); Weiker, Edgington, Kipke.

Program Sponsors:

Evaluation Funding
California Department of Health Services
Office of AIDS, University of California, grant #NIMH/MH42459

Operation
Division of Adolescent Medicine of Children's Hospital, Los Angeles

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Intervention for Pregnant Injection Drug Users

Target Population:

Indicated; pregnant women who had injected any drug in the past 6 months, enrolled in a methadone program and resided in metropolitan Sydney.

Setting:

Random sample of the target group.

Theoretic Basis:

Cognitive behavioural.

Program Description:

Members of the target group were selected from within centres and assigned to either:

- Individually receive a six-session intervention in addition to their methadone program, or
- To a control group, i.e. their usual methadone program only.

The goal was harm reduction not abstinence; that is it was to determine if an intervention would change their behaviour after the session or if there was any change after a 9-month follow-up period.

The data collection included the gathering of basic demographic characteristics, time from last injection and determining their sexual risk. The total risk taking score along with the individuals injecting and sexual risk taking behaviour was determined by applying the HIV Risk-taking Behavioural Scale. The assessment was conducted pre- and post-intervention, and at a 9-month follow-up.

Contact Time:

Six individual sessions.

Leader Type and Training Provided:

Manuals, training (role-playing, modelling), on-going supervision by case discussion and review of taped session.

Intended Outcomes:

There was no change in the drug use by either group immediately post-intervention. The 9-month follow-up however did show the group who had received the intervention, had reduced some HIV high-risk behaviour, specifically injecting behaviour. Sexual risks were not affected.

Author's Comments:

A manual describing the treatment is available from the National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia 2052.

Of possible interest is a manual of cognitive behavioural techniques aimed at reducing HIV risk-taking behaviour in injection drug users: Amanda Baker, Nick Heather, Anna Stallard, Katy O'Neill and Alex Wodak. NDARC Monograph No. 28. ISBN 0-947229-63-9.

In relation to prevention principles, we set clear goals; we evaluated the program; we combined knowledge and skill development (most apparent from the manual that includes handouts on skill power to contrast it with will power).

Reviewer's Comments:

A possible limitation of the study was that information gathered for the review was acquired based on self-report. The assessors did ask multiple questions to ensure consistency and to reduce the impact of this method of data gathering.

The evaluators summarized their findings by stating that an intervention can be of benefit to those who decide to continue injecting despite their methadone program.

Year Program Established:

1992-1993.

Associated Studies:

Evaluation of a cognitive-behavioural intervention for pregnant injecting drug users at risk of HIV infection. (1996); O'Neill, Baker, Cooke, Collins, Heather, Wodak.

Program Sponsors:

National Drug and Alcohol Research Centre, University of New South Wales, Sydney
Drug and Alcohol Service, Westmead Hospital, Westmead
Drugs in Pregnancy Services, Royal Prince Alfred Hospital, Camperdown
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Logan Square Prevention Project

Target Population:

Selective; Latino and African-American Grades 5–8; inner city students.

Setting:

Schools; Grades 5-8 in two Chicago elementary schools.

Community; street
Multiple community organization and agency sites within the defined community boundaries.

Theoretic Basis:

- cognitive – behavioural;
- community development.

Program Description:

The project was the result of local concerns in an area where there was an excessive use of drugs and alcohol by their youth. The neighbourhood association convened representatives from the church, law enforcement, education, and local service organizations to address the issue. The intervention was clearly a collaborative community effort.

The program involves a comprehensive array of school and community based prevention programs focused on reducing alcohol and other drug use as well as reducing gang involvement in the target population. The program is delivered by a coalition of community agencies and is culturally tailored to fit with the youth of the neighbourhood.

The intervention was built on the following principles. Involving numerous agencies will ensure the development and implementation of a comprehensive prevention plan. A long-term concentrated focus will result in a higher dosage of service. The services needed to be culturally sensitive and focus on the issues they wished to address namely, gang participation, academic opportunities and unstructured free time. An intensive program was seen as being the most effective means of reducing alcohol and drug use and abuse.

The goals of the program are to organize the various groups into a consortium that avoids duplication and fosters collaboration and secondly to track the services delivered by the participants through an automatic tracking system. This system provides staff with feedback as to the adequacy of the program.

A youth service agency supervised the project and subcontracted out arrangements to seven consortium agencies. The coordinated range of services was operated and viewed as one network of services in the community. The contracted agencies were responsible for the following:

Churches: provided drop-in activities such as recreational, tutoring, life-skills, substance abuse education, cultural awareness and counselling.

District Police Office: conducted annual gang prevention seminars, organized large sporting events, organized block clubs and parent groups.

Boys and Girls Clubs: two clubs provided the SMART Moves life skills curriculum and engaged target youth in after school activities.

Latino Youth Service Organization: provided bilingual and bicultural in-school substance abuse and life-skill programs.

Chicago Settlement House: provided in school and after school youth and family counselling.

Latino Drug Abuse and Treatment Agency: provided education and support services.

Although the project was multidimensional in its delivery sites, the outcome measurements were conducted in the school.

Contact Time:

Each program had a different contact expectation, and for some like the drop-ins it would be voluntary. The point was to offer and increase accessibility to these programs for the youth population in the area.

Leader Type and Training Provided:

Multi leadership and training used.

Intended Outcomes:

- the consortium of preventive service providers increased it's degree of cooperation and collaboration and has become more decentralized;
- the network reached youth in the greatest need;
- the network members began to exchange information and resources to a more equal degree;
- youth reporting high gang activity received more gang-related prevention programming;
- those who reported high past year substance use had a tendency to receive more substance abuse prevention and life-skills education;
- youth with "Cs" or lower received more tutoring;
- acculturation scales confirmed that first and second generation youth were less acculturated than third generation youth;
- eighth Grade boys with mostly "Fs" on their report cards were more gang involved than others who did not share these characteristics;
- youth who felt close to gangs and those who did not feel close to their families were more gang involved;
- youth in Grade 7 vs Grade 5, boys over girls, and those who had poor grades reported more substance use;
- the post-test cohort had reduced gang activity and decreased alcohol and other drug use with the exception of marijuana;some increase in grades was reported at one study site;
- gang involvement was a strong predictor of substance use.

Author's Comments:

Other explanations for the findings cannot be ruled out; large numbers of youth are very mobile and this prevents full exposure to the program as well as reduces the ability to evaluate program effectiveness.

Reviewer's Comments:

Earlier studies indicated that there are some 17 factors which could contribute to the use of drugs by youth. They included community conditions, family structure, individual preference, and antisocial behaviour to name but a few. Many of these were found to also have some interdependency.

While the evaluation of the project indicated the intervention was having a positive impact on the drug habits of the community's youth, they also identified some limitations that might be influencing their results. In a longitudinal study one needs to be careful in interpreting group changes without being able to compare the results to what is also happening in neighbouring communities.

They also found there was a high rate of student mobility between the two schools. In areas where both schools exhibited a reduction in an activity the impact of the migration might be low, in areas where there were differing trends the impact may be hard to determine, as they did not follow the habits of individual students.

A question they would have liked to answer was, "did the dosage of service have an impact on the youth's outcome?" The evaluators also felt that the length of the youth's exposure to the intervention would be worth pursuing as well.

There are a number of aspects of this program that can be applauded. It offers youth a variety of programs; educational, recreational and treatment oriented in a number of different settings. Community agencies are heavily committed and involved resulting in positive collaborative relationships, a sustainable benefit even after the funding has run out. The agencies involved offered programs related to their own skills and expertise.

The programs were specific to the cultural backgrounds of the youth. They attempted to address some of the risk and protective factors related to environmental factors.

During the project's implementation, each of the organizations and agencies providing service began communicating more with one another. The end result was that there was a more collaborative approach to dealing with the client's needs and the delivery of the services became more effective.

Year Program Established:

1991-1993.

Associated Studies:

Effectiveness of the Logan Square Prevention Project: Interim Results. (1998); Godley, Velasquez.

Program Sponsors:

Delivery:

Chestnut Health Systems
Youth Outreach Services Inc.

Funding:

United States Center for Substance Abuse Prevention
Illinois Department of alcoholism and Substance Abuse

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Prevent Initiation of Drug Users into Injecting

Target Population:

Selective; the drug using population who are at risk of using injection as the route of intake. Most of the sample was composed of older male injectors.

Setting:

Recruitment was from the drug using community, through drug services.

Theoretic Basis:

Attitudinal and behavioural.

Program Description:

The goal of the work was to evaluate the effectiveness of delivering a brief intervention to prevent initiation into injecting. Additionally, further research was conducted into the social processes of initiation into injecting.

There is a recognition that injecting is usually proceeded by non-injected drug use and new injectors learn to do so from more experienced users. The aim of the intervention was to: encourage the seasoned user to think about initiation; to identify and reduce the behaviour that unintentionally results in the initiation; increase the resistance to initiate non-injectors; enhance skills of the injector in dealing with initiation requests.

The intervention was comprised of five distinct sections, which considered: the participant's initiation; their initiation of others; the risks associated with initiation; identifying behaviour aspects that might inadvertently promote injecting; and role-playing initiation scenarios.

Contact Time:

The intervention is brief, it can be delivered in less than an hour. There are no associated costs beyond staff training.

Leader Type and Training Provided:

Peer.

Intended Outcomes:

The sample of current injection drug users indicated they felt that peer pressure was not the reason for them starting to inject; in fact they sought out the initiation. Although pressure from other injection drug users did not influence their decision, the experienced user did play an important role in providing information about the pleasurable aspect of injection and in responding to their requests to teach the drug user how to inject.

Comparing data over a three-month period showed the intervention had reduced the number of initiations, injection drug users had reduced their interaction with non-injection users, and participants reported fewer requests to initiate.

Reviewer's Comments:

Although the sample was small [86 individuals], the findings did show that this inexpensive intervention can result in a change in behaviour in the initiation of drug injection.

In terms of principles, the program had clearly established goals that were linked to activities that reflected the circumstances of the target group. It was recognized that the behaviour of the seasoned user impacted on the new user and in order to change behaviour peer intervention would be required. Skill development and interactive participation would encourage a reduction in the risk of teaching injection skills to the new user.

Year Program Established:

1997.

Associated Studies:

Evaluation of a brief intervention to reduce initiation into injecting Hunt N., Stillwell G., Taylor C., & Griffiths P. (1998) Drugs: education, prevention and policy 5, 2: 185-193.

The modelling of injecting behaviour and initiation into injecting. Stillwell G., Hunt N., Taylor C., & Griffiths P. (1999) Addiction research 7(5): 447-459.

Preventing and curtailing injecting drug use: opportunities for developing and delivering 'route transition interventions' Hunt, N., Griffiths P., Southwell M., Stillwell G., and Strang J. (1999). Drug and alcohol review. 18, 4: 441-451.

Program Sponsors:

Research:

The Mental Health Foundation, London

Consulting:
National Addiction Centre, Institute of Psychiatry, London

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UFO (U-Find-Out) Study

Target Population:

Selective; young injection drug users in San Francisco and Santa Cruz.

Setting:

Street.

Theoretic Basis:

Participants defined it as collaborative, harm reduction, social action, Fierian pedagogy, participatory, anarchy, punk, communism or common sense.

Program Description:

The study started off as a collaborative community project where the workers and the clients began to develop the program over time, which was dependent on the needs identified by the participants.

The initial focus of the study was on examining HIV, HBV and HCV among young injectors. With peer input, the researchers developed a questionnaire that would be used to assess the behaviour patterns of the youth and determine some of the risk factors. Early on in the project, they saw needle exchange as a venue for the interventions they wanted to study. They added the importance of providing a vaccine for HBV to their agenda as well as including an investigation of the major cause of death to the young injector-overdose. Modifying the focus during the review required the cooperation of the researchers, the service providers and the young injectors.

Their goal was to provide testing and counselling, vaccinations, outreach, food and basic medical care to all those youth who they could make contact with. While one part of the team was providing service another was trying to gather data on the behaviour. It was a daunting task and through the use of 'peers' they were able to increase their data gathering through 'one on one' interviews and focus groups.

Contact Time:

Ongoing interaction.

Leader Type and Training Provided:

Peer outreach workers and peer access interviewers.

Intended Outcomes:

The results of the study are based on a summary of qualitative information provided by those who participated in the two-year study:

- Increased benefits for the youth who are injecting drugs: There was an increased awareness on the risks of their behaviour to acquire HIV, HBV and HCV and on where they can seek help and information.

- Enhanced quality of research atmosphere: There was a sense that over time a level of trust was built up so that the youth returned to get service, and brought their partners or friends in for testing, information or to provide information to the research team on their specific behaviour.
- Validation and increased self esteem for youth: Peer workers put them in contact with the high-risk, high-end users in the community that were not being served by other agencies in the area.
- Community building: working outside the community, strengthening inter-agency ties: After the study had concluded the youth who were involved in the study continued to participate with the community outreach youth team.
- Agency legitimacy and a positive evaluation: The providers saw a change in attitude by the community in accepting the outreach team working with this hard core group in harm reduction. There was a substantial increase in vaccinations by the HBV affected youth.
- A voice in research and a good relationship: A good rapport developed and was maintained by the research team and with those outreach workers providing the service.
- Affected clients: Over 700 young injectors were interviewed, tested and counselled. Of those that entered the vaccination program half are still receiving service. The Santa Cruz needle exchange program was the first in the country to get approval to continue with the distribution of the vaccine.

Preliminary quantitative data: the UFO Study is a cross-sectional study of HIV, HBV and HCV infection in young injectors; additionally we have carried out pilot vaccine studies and studies of overdosing.

The UFO study interviewed 696 injection drug users under the age of thirty during 1997-99. In preliminary data on 213 subjects, the average age was 22 with a median of five years of injecting, and a median of three years of needle exchange use. Bisexuality was common in the study subjects. Seropositivity rates were 6% for HIV, 42% for HCV and 33% for HBV; 84% of the subjects had used some form of needle exchange, most frequently secondary exchange network. Nonetheless, 46% reported borrowing a used syringe within the past year.

We found that only 13% of young IDUs in San Francisco had serological evidence of vaccination against HBV. Finding a way to deliver hepatitis B vaccination to the young injector population became the second principal objective of the study. In a pilot vaccine study, 183/228 eligible subjects received the first vaccine dose, an acceptance rate of 80%. The most important reason for not receiving vaccine was not returning for serology results, reflecting transience of the population. With an incentive payment of $10 offered to those returning for the second and third vaccine doses, 77% have received their second dose and 49% have received their third dose to date.

We found that overdosing was the most immediate health concern among young injection drug users. Among 312 YIDU studied, 55% reported at least one overdose and 75% of young injectors had witnessed an overdose. At the most recent overdose witnessed, 52% had called 911, 61% had performed CPR, and 72% kept the person awake by walking them around or shaking them. Eleven percent reported that the person had died.

Author's Comments:

The three prevention principles most applicable to our program are: build a strong framework; strive for accountability; understand and involve young people.

Reviewer's Comments:

The results from the UFO project are very preliminary at this time but it will be interesting to see the four technical papers that are presently being worked on to further examine the outcomes of this study. The success of endeavours such as this can initially be measured through the experiences of the outreach workers in attracting the high-risk youth and in the youth's ability to remain with the program. Workers expressed that they were attracting youth that were not receiving services from any other agency and their numbers were increasing. Outreach workers also indicated that as the trust built up in this illusive population, the youth were requesting to be part of the solution.

The four papers being worked on regarding HIV serology, HCV serology, HBV vaccine adherence and overdoses should provide information on how to best reach the injecting drug youth and how to keep them interested in the program.

The program incorporates a number of prevention principles. The program built a strong framework through links with local agencies offering complementary services. Services reflected the needs and concerns expressed by the target group, and the target group occupied an integral role in the delivery of services. Accountability was integral, as there was a great deal of emphasis placed on the evaluation of services. Youth were involved in the evaluation process to ensure activities could be monitored and revised to reflect the ongoing needs of the population.

Year Program Established

1997.

Associated Studies:

Toward Participatory Action Research: The Challenges and Rewards of Collaborative Study. (No Date). The case of the UFO study, a project of the Haight Ashbury Youth Outreach Team, the Santa Cruz Needle Exchange and the University of California, San Francisco; Ochoa, McLean, Edney-Meschery, Brimer, Moss.

Program Sponsors:

Funding:

Universitywide AIDS Research Program of the State of California

Amount of award, year I: $105,773; year II: $106, 194; supplemental award: $130,000. All of these awards were divided among UCSF Department of Epidemiology and Biostatistics, the Haight Ashbury Youth Outreach Team and the Santa Cruz Needle Exchange.

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Substituting Naltrexone for Heroin

Target Population:

Selective trial; heroin using males and females.

Setting:

Community; individuals who presented for detoxification at the Australian Medical Research Procedures Foundation, Perth, Australia were sequentially recruited into the study.

Program Description:

Following opiate detoxification, the patients were instructed to take Naltrexone at a set dosage orally. Daily administration was the responsibility of the client's 'carer'.

Cessation of Naltrexone was reported back to the clinic by the carer. Staff would immediately follow-up study participants via peer-based networks and encourage re-entry to Naltrexone maintenance, providing prompt detoxification if necessary. There was ongoing counselling available to the participant and carer.

Contact Time:

Daily.

Leader Type and Training Provided:

The carer (often a family member) provided support for the participant to continue in the program as well as supervising daily Naltrexone. Initial training was provided to carers to first, ensure that they would effectively monitor daily oral Naltrexone use and secondly, to ensure that vigilance of supervision was maintained over time.

Intended Outcomes:

The minimum age for participation was 17 years and the maximum age was 47 years. The mean age was 26 years [SD ± 7 years] [47% were aged 22 or less].

A majority was still on Naltrexone six months after beginning the program, although a number of these individuals had returned to heroin use at least once during the trial.

Vigilance of daily supervision of Naltrexone by 'carers' over the first six weeks of treatment is a predictor of improved prognosis at six months.

Reviewer's Comments:

The criteria for this trial resulted in a very young group of participants. The authors indicated that their young chronological age and limited time involved in heroin use could have had an impact on the outcome of the trial. In the discussion they note that the high success rate would have been significantly reduced if a casual return to heroin was considered a criteria for patient failure. Other clinical trials did not make such adjustments and appear to have a much lower success rate.

There was no differentiation in the results between age and success rate, so it is difficult to determine if this regime would be more successful with drug using youth. The study suggested the need for a broader review examining how relationships, employment and other psychosocial factors might affect the outcome.

The trial incorporated some best practice principles, as it experienced an improved prognosis by developing the skills of the 'carers', and through peer dispensing of the medication and daily supervision of the clients.

Year Program Established:

1997-1998.

Associated Studies:

The association between Naltrexone compliance and daily supervision. (2000); Hulse & Basso.

Reassessing Naltrexone maintenance as a treatment for illicit heroine users. (1999); Hulse and Basso.

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Special Focus: A Summary of Evaluations of the Drug Abuse Resistance Education (D.A.R.E.) Program

The "Drug Abuse Resistance Education" (D.A.R.E.) program is the most widely implemented school-based drug use prevention program in the US. It is also increasingly popular among Canadian schools and police forces. A health education specialist, in co-operation with law enforcement agencies, first developed it in California in the mid-1980s.

The primary prevention curriculum is delivered by trained, uniformed police officers to children in Grades 5 and 6 (ages 10-12). Seventeen 45-minute sessions are taught on a weekly basis, spanning the following topics: information about drug effects; media awareness; normative education; peer resistance skills; decision-making skills; self-esteem; healthy alternatives; and personal safety. D.A.R.E. includes a parent program consisting of 6 lessons. Thus, the D.A.R.E. curriculum, revised in 1995, is reasonably comprehensive to the extent that parents of participating students complete the parent component. It contains elements of the informational, affective, and social influences approaches, utilizing both didactic and interactive teaching methods.

There have been many D.A.R.E. reviews and evaluations, but few rigorous scientific evaluations. While some evaluations show positive results,[1] studies published in peer reviewed journals, including a 5-year prospective study and a meta-analysis of D.A.R.E. outcome evaluations, have been consistent in showing that the program does not prevent or delay drug use, nor does it affect future intentions to use.[2,3,4,5,6,7,8] On the positive side, it does seem to boost anti-drug attitudes, at least in the short-term, increase knowledge about drugs and foster positive police-community relations. Also, acceptance of the program is generally quite high among police presenters, students and their parents.[9,10]

There are several possible explanations for the lack of effect on drug use. A primary difficulty may be in the method of instruction. An interactive life skills training approach appears to be most effective in late elementary and junior high years.[11] Yet just 9 of 17 lessons in the D.A.R.E. curriculum give attention to social competency development, and use of interactive teaching techniques is infrequent.[12] Interactive approaches that actively engage students in a variety of participatory activities require unique classroom management and facilitation skills. To be considered truly interactive, program activities and discussion need to be student-focused, and involve the leader in a less central way;[13] consequently, if the program places police officers in a prominent role in the sessions, effectiveness may be inhibited.

It should be noted that many prevention programs have failed to show effect on behavioural outcomes and some of the evaluations hold D.A.R.E. to high standards. To their credit, D.A.R.E. sponsors have shown a willingness to evaluate and to attempt to improve the program over the years. The program was revised in 1995 to include more interactive delivery strategies, and other topics such as violence however, the effectiveness of the revised program is yet to be reported.

While awaiting findings from evaluations of the revised program, it would make sense for sponsors to revisit the program approach to ensure sufficient interactivity among students. This means also reviewing the role of the police officer in delivering the program. Recruitment and training of D.A.R.E. presenters need to give attention to attributes and skills that lend themselves to effective facilitation of interactive lessons. A well-conceived approach that involved police officers co-leading with mental health professionals or students may enhance outcomes as well (meta-analysis has suggested that mental health professionals and peer leaders tend to be effective with this approach).[14]

It is also important that information on substances be accurate and balanced. Messages that exaggerate negative risks and contain moral undertones need to be avoided because they will not be viewed as credible. Programs that demonstrate—explicitly and implicitly—respect for the ability of young people to reason and to draw meaning and insight from their own experiences and that of others will be more effective. Other elements of good practice that may be worth considering are adding booster sessions and increasing the comprehensiveness of the program by collaborating with other prevention interests in the community. It is also important to bear in mind that youth are not a homogeneous population. Greater effectiveness is likely when programs tailor their approach and method to the characteristics (including risk level) of various sub-groups.

Police officers represent a very significant resource for classroom drug education in this country and their efforts need to be supported. It is important that their potential as drug educators is maximized by a recruitment, training and curriculum development approach that is grounded in the available scientific evidence.

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Section 5

Exemplary Canadian Programs

This section presents descriptions of 39 Canadian programs, including eight serving injection drug using (IDU) youth. Among the programs serving IDU youth are treatment programs that are presented in this compendium because they are engaged in the prevention of harmful effects associated with injection drug use. Programs in this section were identified through the following process:

- invited nominations from provincial/territorial government addiction agencies and Health Canada regional representatives;
- filled in gaps with nominations from key informants across Canada, programs known by team and steering committee members, and, in the case of IDU programs, an Internet search;
- developed a questionnaire/template that was sent to a total of 150 programs;
- conducted a first screen on the basis of a mix of considerations (i.e., availability of evaluation report, evidence of sustainability, degree of innovation, the extent to which prevention principles are reflected, and geographic and cultural representation);
- made personal contact with persons associated with youth treatment and general IDU programs to determine the extent to which they work with IDU youth;
- due to lack of available documentation, collected required information from screened-in IDU programs by interview; and
- developed descriptions of 39 programs based on information provided by questionnaire and interview, and forwarded to program sponsors asking for confirmation of information and elaboration in several areas;
- entered information into a fully searchable database.

Headings have been omitted in cases where no information pertaining to the heading was obtained. While outcome evaluations are very rare among Canadian substance use problem prevention programs, many of the programs described in this section have conducted process evaluations. Information concerning these evaluations may be obtained through the identified contact person.

Making Decisions: Grade 6 and Grade 7

Target Population:

Grade 6 and 7 students.

Setting:

School.

Youth Involvement in Program Development or Delivery:

They participated in field-testing of the lessons, offering their feedback and suggestions for improvement.

Youth Needs Addressed:

Provide opportunities for youth to interact, explore and dialogue on issues related to substance use. Promote, in the classroom, opportunities to learn and practice decision-making, communication and refusal skills.

Interventions Used:

Formal instruction/training; Informal learning; Parents awareness/education; Web site.

Intended Outcomes:

Prevent onset/experimentation; Adoption of healthy recreational alternatives; Improved personal and social skills; More accurate understanding of prevalence of drug use; Improved relationship with parents; Improved awareness of services/help.

Program Description:

Both Grade 6 and 7 programs are designed to promote decision-making skills and support the prevention of substance abuse. Activities focus on role-playing, writing, interaction and discussion. Each lesson includes an overview, learning outcomes, vocabulary, learning activities, summary, enrichment and evaluation. Includes reproducible student sheets and parent handouts. Lessons are designed to be taught sequentially - Grade 7 program builds on Grade 6 program.

Contact Time:

Grade 6 students - 8 lessons approximately 1 hour each; Grade 7 students - 7 lessons approximately 1 hour each.

Agencies Involved in Program Delivery:

Classroom Teachers, Nurses, Police, School Counsellors, BC Ministry of Education, Teachers Associations and other Health Education Groups, BC Ministry of Education lists the program as part of Recommended Grade Collection.

Program Costs:

Grade 6 and 7 manuals (both include student sheets) are $24.95 each plus postage and handling (bulk discount is available). Optional teacher training session - $400/group plus travel/accommodation expenses for presenters.

Prevention Principles Most Reflected:

Strive for accountability; Understand and involve young people; Create an effective process.

Year Program Established:

This version of the program since 1999; original version since 1983.

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Peer Support Program

Target Population:

The primary target groups for this program are children and youth ages 9 - 17.

Setting:

School.

Youth Involvement in Program Development or Delivery:

Youth identify the needs and issues that are relevant to them and their peers. Based on identified needs and issues. Youth develop an action plan including which issues they will address and how. Youth help with hosting and planning special events offered through the PEERS Society including networking meetings and the annual youth conference.

Youth Needs Addressed:

To train youth to reach out and support their peers; to address relevant issues of friendship, loneliness, family relations, communications, school achievement, and peer pressure and substance abuse.

Interventions Used:

Formal instruction/training; Informal learning; Awareness events; Resource centre; Peer teaching; Peer counselling/referrals; Social activities; Counselling; Group facilitation. Team and activities are monitored by trained and competent staff, most of whom are school personnel.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Improved personal and social skills; More accurate understanding of prevalence of drug use; Improved relationship with parents; Improved awareness of services/help; Increased community awareness.

Program Description:

The Peer Support Program is a voluntary program. Youth are identified and selected to be on the team based on a variety of criteria. A main criterion is a young person's interest in helping others. Youth are provided training in interpersonal and helping skills. Initial training is often done through an experiential retreat. Additional training is offered in issues of relevancy, including conflict resolution, drug prevention and early intervention, suicide prevention, etc. As a youth directed program, issues of relevance to each team's context are identified.

The program model is an outreach program as youth are trained to reach and support their peers. Ideally, the team has representation on all the groups in the school so that in turn team members reach out to all populations in the school. Activities vary depending on the issues identified, the context and the team's abilities and framework (can include: one-on-one support, school-wide activities, such as Random Acts of Kindness, drug awareness week, team-building activities, community activities such as working with homeless people, supporting seniors, and assisting children in the library, to name a few).

Most teams hold regular weekly meetings as a means to monitor the program, offer support and provide ongoing training and group cohesiveness. The peer group often provides a link to an adult when extra support and intervention are required; provides an early intervention and referral process when necessary. The program intends to influence the school/community environment, toward being more caring and supportive where youth feel they belong.

There are approximately 60 teams each year in Calgary and surrounding areas. Teams members range in age from 10 to 17 years of age; elementary, junior and senior high.

Contact Time:

This varies from team to team but the program is ongoing and youth can participate over more than one year.

Agencies Involved in Program Delivery:

The Peer Support Program was developed by the Alberta Alcohol and Drug Abuse Commission (AADAC). The Peer Enhancement, Empowerment, and Resources for Students (PEERS) Society (a non-profit agency that provides an umbrella organization for Peer Support Teams); School boards; Schools; Family and Community Support Services.

Program Costs:

The PEERS Society is currently a United Way funded agency. Dollars received go toward supporting teams with their training and activities. Over and above support from PEERS, teams undertake fund raising and are supported to some extent by the schools. About $7,500/year for team functioning and $10,000/year for the youth conference.

A small amount of dollars are spent on visibility and promotions, including an agency brochure, network support to teams hosting meetings, such as honouraria to guest speakers and hospitality costs, facilitator training and administrative costs such as an annual audit.

Prevention Principles Most Reflected:

1. Addresses protective and risk factors: Develops youth competencies; Creates a caring environment; Identifies issues of concern; Provides meaningful youth involvement.
2. Understands and involves youth: youth are involved in identifying issues relevant to them; youth decide which issues to address and how; promotes healthy youth development.
3. An effective process: group interaction, combine knowledge and skills development.

Year Program Established:

Peer Support Program - 1980's; PEERS Society – 1991.

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Student Alcohol and Drug Use Policy and School Curriculum Resources

(Student Alcohol and Drug Use Policy: A Guide for School Boards; Educating Students about Drug Use and Abuse: Ready to Use Lesson Plans for Drug Education in Your Classroom, Curriculum Guide, Curriculum Support for the Ontario Curriculum, Grades 1-10 Health and Physical Education, Substance Use and Abuse; Virtual Party Web Site).

Target Population:

Universal; school administrators, teachers, guidance counsellors, students in Grades 1-12.

Setting:

School; Community; Cyberspace.

Youth Involvement in Program Development or Delivery:

School Boards are encouraged to involve students directly in their policy development process. The Virtual Party stories were developed by a team of youth and pilot tested with 6 youth groups around the province. Feedback and suggestions for improvement were incorporated in the storylines prior to the development of the Web site. One of the original story development team members participated in the launch and media conference and continues to be active on the project team.

Youth Needs Addressed:

The Student Alcohol and Drug Use Policy addresses prevention of drug use, through ongoing drug education efforts; early identification and referral to identify youth before drug use becomes a serious problem; disciplinary procedures to deter drug use on school property and to provide a means of intervening with youth who have serious problems. Drug education support materials promote opportunities to learn and practise decision-making, communication and refusal skills. Virtual Party provides opportunities for youth to interact, explore and dialogue on issues related to alcohol. Both resources provide factual information about alcohol and other drugs, as well as the skills to make appropriate decisions.

Interventions Used:

Policy development; Formal instruction/training; Informal learning; Identification and referral; Web Site; Local media.

Intended Outcomes:

Prevent Onset/experimentation; Reduced use; Improved personal and social skills including decision making; Improved awareness of services/help; More accurate understanding of prevalence of drug use; Improved substance-related policies in schools.

Program Description:

The purpose of a school board policy is to prevent alcohol and drug use among students, and to identify and provide assistance to those students who might already be involved in problematic use of substances. Policy initiatives have been demonstrated to be effective in reducing alcohol and other drug use. Developing policy through an inclusive process (i.e. with representation

from school, parents, students and community) will increase the likelihood of its acceptance and implementation. The resource "Student Alcohol and Drug Use Policy: A Guide for School Boards" describes the components of a successful policy: ongoing drug education, a process for early identification and referral, and disciplinary procedures, including treatment options. It also includes a model school policy that school boards can use as a template.

In order to meet the requirements of the drug education component, school staff can use the resource, "Educating Students about Drug Use and Abuse: Ready to Use Lesson Plans for Drug Education in Your Classroom". It includes lesson plans and support materials, in both English and French, that meet the expectations of the substance use and abuse component of the Ontario Health and Physical Education Curriculum and have been approved for school use by the Ontario Curriculum Centre. The content of the teaching/learning strategies include objective, factual information and are not value based. These strategies and assessment devices provide teachers with the tools to reinforce instruction and to accurately assess student learning.

The curriculum is Web-based for easy access. Links are made to other resources and Web sites focusing on substance use and youth issues. One of the links in Grades 9 and 10 is made to the Virtual Party Web site, developed by a youth team, under the auspices of CAMH. Virtual Party is an interactive, education Internet-based resource simulating a party situation, providing information to youth about alcohol, emphasizing healthy choices and imparting skills for the reduction of harm. It is targeted at youth between the ages of 13 and 19. The young person is able to choose either a male or female character and make choices about their activities during a "virtual" evening. Storylines related to marijuana use and concurrent disorders are currently under development.

CAMH also provides training to support policy implementation and delivery of the curriculum. Standardized training packages are available for teachers, guidance counsellors and other staff, as well as customized in-service training.

Contact Time:

It is recommended that school boards develop their own policy, using the guidelines in the resource manual. They will need to strike a policy development committee, with representation from school staff, parents, students, and other interested parties. Time involved in policy development may vary, but would typically take 6-12 months, involving one committee meeting per month. Once the policy is in place, all students would be involved in the drug education component, but only a few would receive services through the early intervention or disciplinary procedures. Lesson plans are available for all Grade levels and can be easily adapted to time available in class; from 10-15 minutes in primary classrooms to a full 75-minute period in high school. Lesson plans are included for each learning expectation, 3-4 lesson plans for each of Grades 1-8, and 8-10 for each of Grades 9 and 10. Also included are teacher assessment tools, and background resource materials.

Agencies Involved in Program Delivery:

Members of the policy development committee may include: police, youth addictions agencies, other community-based youth services, and recreation programs. The curriculum materials were developed in partnership with School Boards, Public Health units, OPHA – Alcohol Policy Network, PAD Drug Education and Support Services, Association to Reduce Alcohol Promotion in Ontario and OPHEA (Ontario Physical and Health Educators Association). Virtual Party was developed in partnership with the Peterborough County-City Health Unit, and Teen Net (University of Toronto).

Program Costs:

The primary cost related to policy development and implementation of the curriculum component is staff time. Both *Educating Students about Drug Use and Abuse Ready to Use Lesson Plans for Drug Education in Your Classroom Curriculum Guide* and *Virtual Party* are Internet based resources and available free of charge in both English and French on the Web. Customized training is provided on a fee-for-service basis, for teachers, guidance counsellors and other school staff to support them in implementing both the drug education component of their school prevention program, and the identification and referral component. "Teacher Training in Prevention" and "Youth and Drugs" are standardized training packages that are available for a fee.

Prevention Principles Most Reflected:

Comprehensiveness: parents, students, and community agencies are involved in policy development; community agencies are used as a referral network. Comprehensive policy supports drug education, identification and referral, disciplinary action and treatment options.

Program duration and intensity: policy calls for ongoing drug education for all grade levels and curriculum materials provide specific lesson plans and assessment tools for Grades 1-10.

Curriculum materials are based on accurate, research-based information, clear and realistic goals. Older grade levels include harm reduction strategies, plus Virtual Party Web Site.

Sustainability: policy is integrated into school board policies to address sustainability; curriculum is delivered by teachers themselves, and training for teachers and other staff is available. Support materials are easily accessible and can be integrated into existing Board documents.

Youth involvement: youth are encouraged to be involved in local policy development committees; virtual party Web site developed by youth for youth.

Knowledge/skill building: drug education component calls for implementation of a curriculum involving both knowledge and skill development components. Curriculum support materials address both knowledge and skill-building strategies in every grade level.

Year Program Established:

Student Alcohol and Drug Use Policy: A Guide for School Boards was produced in 1991. The curriculum support materials, including Virtual Party Web Site, were developed in 1999/2000, with new components available in 2001.

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Teens Against Drinking and Driving (TADD)

Target Population:

TADD is for students ages 16-21.

Setting:

School.

Youth Involvement in Program Development or Delivery:

This is a student-led program; they plan all activities.

Youth Needs Addressed:

To increase the awareness of the dangers of driving while impaired.

Interventions Used:

Informal learning; Awareness events; Resource centre; Social activities; Counselling; Local media; Web Site.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Adoption of healthy recreational alternatives; Improved personal and social skills; Improved relationship with parents; Improved awareness of services/help; Increased access to services; Increased community awareness; Improved substance-related policies in schools, health, social, police services.

Program Description:

The TADD Program is a student-based program that brings their concerns of the inherent dangers of drinking and driving not only to the students but to the community at large; in other words, everyone. Since 1985, the Awareness Program has been designed to eliminate the impaired driver on our highways by promoting alcohol awareness through peer education programs and activities.

Contact Time:

TADD Executives meet once a week - 1 hour; TADD general meeting once a month – 1 hour.

Agencies Involved in Program Delivery:

RCMP, City Police, Department of Transportation, Department of Education, Policing Services, Health and Community Services.

Program Costs:

As it is a school-based program the cost of operation each year depends on the activities the students plan (t-shirts, assemblies, guest speakers, poster campaigns, provincial conferences, CYAID conferences, multi-media events, etc.). The approximate cost would be $8,000 - $10,000 yearly.

Prevention Principles Most Reflected:

Build a strong framework; understand and involve young people; create an effective process.

Year Program Established:

1985.

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Tuning In To Health

Target Population:

Students Grades 2 to 9.

Setting:

School.

Youth Involvement in Program Development or Delivery:

Focus group / pre-test only.

Youth Needs Addressed:

Manitoba Education requires that learning resources be available to students in the school setting.

Interventions Used:

Formal instruction/training.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Adoption of healthy recreational alternatives; More accurate understanding of prevalence of drug use; Improved personal and social skills; Improved awareness of services/help.

Program Description:

Program contains a total of 62 lesson plans on hazardous chemical substances, medicines, alcohol, tobacco and other drugs, for Grades 2 through 9 (the Early Years package for Grades 2 and 3 contains 11 lessons; the Middle Years package for Grades 4-6 contains 20 lessons; the Junior High package for Grades 7-9 contains 31 lessons). Junior high modules on alcohol, tobacco and other drugs include Grade level pre-test and post-test student assessment questionnaires. Early Years, Middle Years and Junior High packages are available in English and French versions.

Contact Time:

Number of sessions vary from school to school. Most sessions would last one class period. Multiple lesson plans available for each grade level from Grade 2 to Grade 9.

Agencies Involved in Program Delivery:

The program was developed by the Addictions Foundation of Manitoba for school systems.

Prevention Principles Most Reflected:

- Address risk and protective factors: Program emphasizes knowledge and skills related to identifying and countering social influences as well as identifying healthy alternatives;
- Seek comprehensiveness: Tuning In To Health was designed to be one component of a broader comprehensive health curriculum for Manitoba schools. Implementation normally includes community parent awareness/orientation sessions;

- Ensure sufficient program duration and intensity: The program was designed to encourage continuous delivery through successive grade levels with each grade level providing a series of complementary lesson plans;
- Base program on accurate information: This element is part of the foundational program rationale;
- Set clear and realistic goals: Program based on strategic plan and all lessons identify expected outcomes;
- Evaluate the program: Program development involved focus and field tests. The Junior High program incorporates pre- and post-test questionnaires to aid in student learning assessment;
- Address program sustainability: Sustainability was initially ensured by an agreement between the publisher and the department of education to collaborate in all phases of design, implementation, distribution, teacher in-service training and parent orientation;
- Accounting for the implications of adolescent development: This element is part of the foundational program rationale;
- Recognize youth perceptions: The program lesson plans are interactive and promote student participation in discussion and content development;
- Develop credible messages: The program is delivered by a trained educator;
- Combine knowledge and skills development: This element is part of the foundational program rationale;
- Use interactive group process: Lessons plans promote the use of both small and large group discussion formats. The use of peer-assisted learning is also encouraged;
- Give attention to teacher/leader qualities and training: The Addictions Foundation of Manitoba (AFM) assisted the Manitoba Education and Training with teacher in-service training across the province. After the initial implementation training was complete, AFM continued to provide follow-up training services to schools on a request basis.

Year Program Established:

1983-1986.

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Your Life: Your Choice!

Target Population:

Grade 8 students.

Setting:

Family; school.

Youth Involvement in Program Development or Delivery:

Target group (13-14 year olds) participated in needs assessment, design and pilot testing phases, as well as in the formative and summative evaluations.

Youth Needs Addressed:

Alcohol use and misuse information and education.

Interventions Used:

Web site; Informal learning; Formal instruction/training; Includes parent section on the Web site (http://www.schoolnet.ca/alcohol).

Intended Outcomes:

Prevent onset/experimentation; More accurate understanding of prevalence of drug use; Reduced use.

Program Description:

The project goal is to improve the quality and breadth of alcohol abuse prevention education in Canadian schools. More specifically, it contains educational resource materials for 13-14-year-olds that support the acquisition of information and the development of skills and attitudes on the use and misuse of alcohol. A classic iterative learning design approach was taken in designing the site. First, an extensive literature review was completed. Then, discussion group research was undertaken with students, teachers and parents in New Brunswick - all reacted positively to the concepts involved in the project. Initial design concepts were reviewed by an advisory panel of teachers, addictions specialists and other stakeholders. A subsequent development phase culminated in pilot testing and revision processes throughout the spring and fall of 1999. Curriculum specialists in all provincial and territorial governments were consulted regularly between 1997-2000. A sequenced, phased evaluation design was developed that incorporates bench-marking student knowledge, attitudes, skills and behaviour in modified pre/post-test or control/experimental research designs. Evaluation results indicate that Your Life: Your Choice! offers advantages over other opportunities to learn about alcohol (Hughes, 2000). The Student section contains interactive Web activities such as a quiz, ideas for class projects and other activities that will help students learn about alcohol in many different ways. The teacher section describes the key learning outcomes supported by the student activities, ways to use the Web and classroom activities appropriately, and alternate paper-based strategies should technical challenges limit class access to the Web site. The Parent section contains tips for communicating with a young teen about alcohol, directs parents to sources of information in the site and introduces other parents' views on alcohol. The

Information Resource Centre contains "library" materials that support the student, teacher and parent sections. The Gallery is a place where teachers can post examples of students' class projects and where teachers, students and parents can share ideas about how they have used the site. A Guided Tour, Glossary and other support materials are included in the Web site to facilitate online and offline applications of the materials. No section is password protected.

Contact Time:

Discretionary; highly flexible modular design; contact time is appropriate to needs and available time resources.

Agencies Involved in Program Delivery:

Formal project partnership: MacGuire Mangham Associates (NS/BC), NB Tel, New Brunswick Department of Education, New Brunswick Department of Health and Community Services, Performx Inc. (ON/NB), Judy Roberts and Associates/Associés Inc. (ON), Université de Moncton and University of New Brunswick. Partnership members consulted regularly with curriculum development and addictions specialists from all provinces and territories throughout the Web site development process. The Brewers Association of Canada initiated and funded the project as part of its ongoing commitment to the responsible use of its products. Seven teachers in six schools and more than 250 students were involved in the final formal pilot test in English-language New Brunswick schools. To date, the Web sites have been approved by the Ontario Curriculum Centre as "supporting important concepts in the Health and Physical Education curriculum for students in Grades 7-9" in both languages. The English modules have been officially approved by the Curriculum Development Advisory Committee as a resource for the Grade 8 Health Curriculum in the Anglophone sector of the public schools of New Brunswick. The resources have been officially approved as support materials in the Francophone sector of the public schools of New Brunswick and parts of the French-language materials have been selected as formal curriculum. Approval processes are ongoing in all other provinces and territories.

Program Costs:

No charge for access to the national site; free copies of the Web source codes (with no copyright limitations) available to provincial/territorial stakeholders to create customized versions; promotional literature available at no charge; resource personnel available until June 2001 at no charge (fees and expenses covered by funder) to offer workshops and train-the-trainer events.

Prevention Principles Most Reflected:

Protection and risk factors addressed: through numerous exercises, students consider attitudes and behaviours that put youth at risk for undesirable outcomes of alcohol use - i.e. accepting rides from drinking drivers, giving in to peer influence to illegally consume alcohol in at-risk situations, learning coping skills for at-risk situations and considering alternative activities that are incompatible with alcohol use. Program based on accurate information: via Web site links, environmental scans and literature reviews, students are able to access current thinking in the alcohol education field and consider its applicability to their own school and community.

Interactive group processes used: structured classroom activities, Web site-based games and quizzes, facilitated discussions and other formats provide students with multiple ways to access information, consider its relevance to them and to their community and explore alternative ways of looking at alcohol-related issues that affect their lives.

Year Program Established:

2000.

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Developing Capable People (DCP)

Target Population:

Parents; Teachers; Counsellors; Childcare Workers; Adults working with children, Teens or Families.

Setting:

Community; School; Family.

Youth Involvement in Program Development or Delivery:

Youth were surveyed and consulted regarding development of materials.

Youth Needs Addressed:

Prevention of substance abuse; Suicide; Teen Pregnancy; School Dropouts; Gangs; Crime; Health Risks; Violence.

Interventions Used:

Formal instruction/training; Informal learning; Resource Centre; Web Site.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Adoption of healthy recreational alternatives; Improved personal and social skills; Improved relationship with parents.

Program Description:

DCP is an educational training program for parents, teachers, psychologists, childcare workers, family counsellors, police officers and others in a position to influence the lives of young people in a positive manner. The program consists of eight 2 - 1/2 hour sessions and is facilitated by a Certified Program Leader. Sessions feature experiential activities, use of a Participant Workbook and a video. Topics covered are:

1. Understanding change and managing adversity;
2. Understanding the power of perceptions and personal belief systems;
3. Creating the perception of personal capability;
4. Creating the perception of significance;
5. Creating the perception of personal power;
6. Developing strong intra-personal skills;
7. Developing strong systemic skills (social responsibility);
8. Developing strong decision-making skills.

Contact Time:

Adults attend 9 - 21/2 hour sessions.

Agencies Involved in Program Delivery:

Psychologists, Social Workers, Teachers, Parents, Childcare Workers, Clergy, Police, Public Health, Nurses, School Counsellors.

Program Costs:

1. Minimum cost to attend the regular eight-session program is $25.00 plus GST. This amount covers the cost of the Workbook. DCP Leaders may charge varying fees to participants over and above the workbook costs to cover related expenses.
2. Three day Leader Training Programs are available across Canada for adults wanting to learn how to facilitate sessions. Cost is $495.00 plus GST, which covers the 3-day training and all materials (i.e., Leaders' Manual, Participant workbooks and the eight videos).

Prevention Principles Most Reflected:

1. The DCP program builds a strong framework by: addressing protective and risk factors for youth in homes, schools, and communities; complementing the prevention efforts of others in the community responsible for healthy youth development.
2. The DCP program strives for accountability by: encouraging participants to understand the challenges facing youth from a local perspective; providing ideas and strategies for sponsors that assist others to personally integrate and apply key concepts.
3. The DCP program understands young people by: assisting adults to understand the stages of development, causes of substance abuse; conditions for developing in a healthy way.
4. The DCP program creates an effective and realistic process by: teaching participants how to communicate effectively with youth; and how to manage discipline issues.

Year Program Established:

1992.

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C3 (Community Cooperation for Change): A Workable Solution

Target Population:

Youth in malls

Setting:

Community.

Youth Involvement in Program Development or Delivery:

Youth are involved in identifying issues and resolving problems.

Youth Needs Addressed:

Positive use of leisure time.

Interventions Used:

Social activities; Referrals; Resource centre; Drop-in centre; Formal instruction/training; Local media.

Other Interventions:

By identifying problems in the mall, various solutions have been found, from a youth-operated car wash in the parkade to a school in the mall.

Intended Outcomes:

Adoption of healthy recreational alternatives; Improved awareness of services/help; Increased access to services.

Program Description:

Drop-in Component

Our storefront model provides easy access for youth to drop in and ask questions related to drug use.

Community Collaboration

We work with community agencies to do creative projects on drug use. These include information workshops, developing Web sites on drug use, and outreaching to local schools.

Material/Resources

We provide up-to-date materials on all aspects of drug use and it's effects as well as connect youth to the appropriate services.

Supportive Counselling

Professional Counsellors are referred from partnering agencies to counsel on substance abuse CAMH (Centre for Addiction and Mental Health and SAPACCY) (Substance Abuse Program for African Canadian and Caribbean Youth). Free and confidential individual and family counselling, contact intake worker to schedule appointment.

Youth Committee

Meets once a week to plan and participate in preventative workshops on youth substance abuse.

Contact Time:

Varies.

Agencies Involved in Program Delivery:

Businesses; Schools; Health and social services agencies; Local government; Law enforcement, Residents.

Year Program Established:

1996.

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Communities in Action for Children and Youth

Target Population:

Adults and youth who can have a significant impact on children and youth.

Setting:

Community.

Youth Involvement in Program Development or Delivery:

Youth have been involved in the training workshops for Developmental Assets, in conferences and have participated in steering committee meetings.

Youth Needs Addressed:

The committee supports the research of the Search Institute that indicates that there are 40 assets that children need to be successful and promote the development of these assets.

Interventions Used:

The project refers to the research of the Search Institute concerning the "developmental assets" that children need to be successful and promotes the development of these assets. Formal instruction/training; Awareness events; Resource centre; Local media.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Adoption of healthy recreational alternatives; Improved personal and social skills; Improved relationship with parents; Improved awareness of services/help; Increased community awareness; Improved substance-related policies in schools, health, social, police services.

Program Description:

Communities In Action for Children and Youth (CIACY) is a working group of agencies and interested citizens that are committed to supporting the healthy development of children and youth and making children and youth a priority in Calgary. CIACY's vision is of a city and region where all youth are respected, valued and encouraged.

CIACY embodies the principles and goals of the Search Institute's "Healthy Communities, Healthy Youth" (HCHY) initiative that promotes the positive development of all children and adolescents. A pivotal component of the HCHY initiative is the promotion and implementation of the Search Institute's "40 Development Assets" framework. Research by the Search Institute has identified 40 concrete, positive experiences and qualities, "Development Assets", that have a tremendous influence on young people's lives. These assets are things that people from all walks of life can help nurture. Search Institute's research has also shown that the "40 Development Assets" help young people make wiser decisions, choose positive paths, and grow up competent, caring and responsible.

The work of CIACY endeavours to heighten the capacity of Calgary's citizens and organizations to make positive differences as an "Asset Builder" by (1) raising Calgary's consciousness about the urgency and feasibility of mobilizing individuals, communities, policy makers and resources

to take positive action on behalf of all children and youth; (2) providing assistance so that communities develop and implement coordinated, long-term efforts to promote the healthy development of all children and youth; (3) motivating children/youth-serving organizations and institutions to develop and implement asset-building strategies; (4) motivating and equipping families to build developmental assets; (5) modelling the assets concepts in the respective workplaces and communities of the Communities in Action for Children and Youth members; (6) actively engaging children and youth in building assets in their own lives and the lives of their peers, and in contributing to community initiatives; and (7) celebrating successes by acknowledging individuals, groups, and organizations that practice asset-building.

Contact Time:

Varies.

Agencies Involved in Program Delivery:

This project is delivered by a collaboration of youth-serving agencies and community members: Aboriginal Resource Centre, North of McKnight Community Resource Centre, AADAC Youth Services Calgary, Boys and Girls Club of Calgary, City of Calgary, Child Friendly Calgary, Calgary Board of Education, Calgary Between Friends Club, Calgary Rocky View Child and Family Services, Council of Sikh Organizations, Calgary Regional Health Authority, YMCA, Calgary Catholic Board of Education, Calgary SCOPE Society and Community and Youth Representatives. Currently setting up a provincial infrastructure to promote Developmental Assets.

Program Costs:

Total budget for the year 2000 was $63,000: staffing (April-December); newsletter (1250 copies printed/distributed); Web site creation and fees; orientation sessions (approximately 16); one speaker bureau/volunteer training session (25 attendees); staff development (conference attendance); purchase of materials (books, videos, posters, etc.); handouts supplies etc.; consultation with the Centre for Non Profit Management; youth training sessions (20-25 attendees); incidentals.

Prevention Principles Most Reflected:

Building a strong framework: educate and promote on the importance of protective factors (asset building); create and sustain partnerships with individuals, agencies, organizations and policy makers. Strive for accountability: the developmental asset approach is based on data compiled by the Search Institute - to date hundreds of thousands of students have been surveyed ("Profiles of Live Survey"); Communities in Action for Children and Youth has developed a Strategic Business Plan, and each of the five Standing Committees report to the CIACY Steering Committee; the research and evaluation committee is developing a survey tool to administer to Calgary and area students, this data will then be used for community mobilization; Communities in Action for Children and Youth offers support to individuals, agencies and organizations who wish to incorporate strength-based approaches into their programs and activities. Understanding and involving young people: the developmental assets research shows a correlation between assets and substance use - the more assets, the less substance use; involve youth in planning, consultation and delivery of presentations and training.

Year Program Established:

1998.

Contact:

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Drug Education and Awareness for Life (DEAL)

Target Population:

Youth having access to the Internet.

Setting:

Cyberspace.

Youth Involvement in Program Development or Delivery:

Youth are involved in design and maintenance of the Web site; recruitment of youth within communities to write articles for the on-line magazine (DEAL Web-zine) on issues such as drugs.

Youth Needs Addressed:

Information on substance abuse and related problems; information and links on a range of topics of concern to youth (violence, intolerance, self-esteem, etc.) that may lead to substance abuse and other destructive behaviour.

Interventions Used:

Counselling; Web Site; Formal instruction/training; Informal learning.

Other Interventions:

Provide processes and tools for youth to learn about problem-solving and encourage them to deal with issues facing them in their school and community; DEAL Web-zine provides platform for young engagement and empowerment where they can promote initiatives and solutions to substance abuse and other issues.

Intended Outcomes:

Increased community awareness; Reduced use; Prevent onset/experimentation; Increased community awareness; Adoption of healthy recreational alternatives; Improved substance-related policies in schools, health, social, police services.

Program Description:

DEAL is about using the Internet as a tool to challenge young people to get involved in problem-solving issues of concern in their school and community. The DEAL site is a "for youth by youth" initiative that enables young people to speak out on issues, promote healthy lifestyle choices and promote youth-related initiatives aimed at building safer and healthier communities. Content development is driven by the need identified by the audience and through the partnership with youth, community agencies, businesses and other stakeholders. The DEAL site is designed to provide localized information and to serve as a platform to promote local initiatives. DEAL wishes to be the Internet portal of choice to assist youth, parents, teacners, and others by directing them to information and tools offered through local, national and international sources.

Contact Time:

Varies depending on activities: Internet contact through surfing, e-mail, forums, and chats/conferencing; direct contact through community-based activities and projects related to DEAL but facilitated through front-line officers, teachers and youth leaders.

Agencies Involved in Program Delivery:

Schools; youth service agencies (Scouts, Guides, Boys and Girls Clubs etc.); businesses as corporate sponsors; other police agencies; other Internet sites (AOL Canada, E-pals, etc.).

Program Costs:

Funding support for development secured through SchoolNet; supporting funding from RCMP; in-kind funding through corporate partners.

Prevention Principles Most Reflected:

- Framework: DEAL is designed as a tool that supports, promotes and complements existing programs and initiatives being delivered at the local level by police and other service providers; the interactive nature of DEAL and the Internet is used to engage and challenge as well as inform.
- Accountability: DEAL and the Internet provide a framework for feedback, assessment, and evaluation that looks at performance indicators to evaluate the reach, impact and relevancy of our efforts; our goals are driven by our efforts to meet the needs of the audience at the local and national levels; front-line officers and other community partners (schools) become partners in service delivery; sustainability is driven by the growing partnership at the local and national levels.
- Understand and involve young people: DEAL is driven by young people and their involvement is what created DEAL and what makes it work; from design and development to delivery, young people are directly involved in the entire process where adults act as mentors and facilitators; youth ownership in this program provides the credibility and validation it needs to have an impact on its audience.
- Create an effective process: the DEAL program has developed processes that encourage young people to get involved in developing the site and delivering its initiatives; through these processes, we wish to provide young people with an opportunity to develop valuable and marketable skills such as team building, problem-solving, project management, Web development, communication and others; by getting youth involved in delivering content for the site, we encourage them to do research and deliver messages that are relevant and geared toward the audience for maximum impact; the Internet provides a level of interactivity that enables us to be creative and innovative in how we reach the audience; we promote exchange and collaborative projects for schools and others to allow youth to share knowledge and demonstrate leadership.

Year Program Established:

1997.

Contact:

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Media Arts Program

Target Population:

Universal; Selective.

Setting:

Community; School.

Youth Involvement in Program Development or Delivery:

As a participant-driven program, youth are involved in every aspect of the production process. Youth participants chair weekly meetings and provide regular input to the program structure, directions and organizing activities.

Interventions Used:

Web Site; Adult or older youth mentors; Drop-in centre; Informal learning; Local media; Social activities; Peer teaching; Dissemination of resources.

Intended Outcomes:

Prevent onset/experimentation; Improved relationship with parents; Improved personal and social skills; Increased access to services; Increased community awareness; Improved substance-related policies in schools, health, social, police services; Reduced use.

Program Description:

The Media Arts Program is a substance abuse prevention program that seeks to use media technology as a tool for change – stimulating discussion, information sharing, awareness and action on substance use and other issues of concern relevant to youth.

Objectives

- to provide a supportive environment for youth to voice their concerns and express their creative talents;
- to provide opportunities for youth to identify and explore their own health education interests in the area of substances;
- to foster mentoring relationships between participants and people working in media related industries;
- to present opportunities for participants to learn about the educational and career options in the area of media;
- to provide opportunities for youth to learn valuable media related skills and knowledge;
- to encourage and facilitate the production of media peer education resources.

The Media Arts Program began with the establishment of yearly after-four video clubs that were designed to foster awareness of drugs and alcohol among students 8 - 13 years. The Drug Awareness Video Clubs were held on a rotating basis in local area schools. Each club operated for a duration of three months. Facilitated by a program staff member, participants at each school would meet weekly to learn the basic operations of a video camera and to understand and decipher drug education materials (often brochures produced by the former Addiction Research Foundation). Participants would then get together in small groups to reinterpret the information and produce short drama scripts, which were filmed on video. Afterwards participants were encouraged to play a leading role in presenting the video to their classmates, which often provoked discussion.

The videos were considered to be clear indicators that the program was successful in getting young people to regularly meet, discuss and learn about the effects of substance use.

Today the Media Arts Program revolves around older youth and has expanded to include other forms of media and year-round activities. Currently there are three main program activity areas:

- print (newspaper and Web design),
- radio (also includes audio art),
- video (also includes photography and film),

Contact Time:

Varies.

Agencies Involved in Program Delivery:

Interagency collaboration is a regular component of the Media Arts Program's service delivery. Most of the media products that are produced by program participants are developed in partnership with community agencies or associations. These partnerships help inform the program participants about the issues that they are engaged in. Here are some examples:

- Each issue of Catch da Flava (a quarterly newspaper produced by the Media Arts Program) is developed in partnership with an association or community group. In 1998, the Ontario Secondary School Teachers Federation sponsored and disseminated 100,000 copies of a Catch da Flava newspaper issue about the provincial election process and the importance of youth voting.
- In 1997 the Media Arts Program partnered with a local elementary school and the Toronto Board of Education's Protective Behaviours Network to work with Grade 6 students to produce a video on strategies that young people could use to protect themselves against bullying and intimidation. The video was disseminated by the Protect Behaviours Network and is currently in use as an educational resource.
- More recently, this past summer Alcohol and Drugs Concerns Canada worked with summer program participants to co-produce a video promoting drug prevention strategies among students entering high school. The video is intended to be disseminated to junior high schools across Ontario.

- The radio program often regularly features information about community groups and associations that are working to improve the health of youth. An upcoming holiday show promoting awareness of alcohol abuse will feature representatives from the Association to Reduce Alcohol Promotion in Ontario (ARAPO) and youth participants of "In The Drivers Seat", a school-based alcohol prevention program supported by the City of Toronto Public Health Department.

Program Costs:

Program Staff: $50,000 yearly; Program Supplies: $15,000 yearly (This does not include capital equipment costs)

Prevention Principles Most Reflected:

The underlying premise behind the Media Arts Program is a belief that health education strategies are more effective when they are planned and implemented by the people they are targeted to serve. This means that young people are supported and encouraged to take a leading role in designing and developing resources that are geared to young people.

Media (newspapers, magazines, TV programs, and radio programs) constitutes the major source of information in factors that impact on youth values and lifestyle choices. The Media Arts Program capitalizes on young peoples' interests in media production to promote healthy lifestyles and teach valuable skills. Healthy lifestyle or anti-drug media campaigns serve to reinforce other community preventive efforts and can increase community participation, knowledge and awareness of issues.

Year Program Established:

1992.

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Opti-Jeunesse : Une force contre la toxicomanie

Contexte :

Communauté.

Participation des jeunes à l'élaboration ou l'exécution du programme :

Les jeunes s'investissent dans des activités de sensibilisation auprès de leurs pairs. Ils sont encadrés par des éducateurs ou des intervenants. Éducation par les pairs.

Besoins visés :

Besoins de sensibilisation et d'éducation, compétences personnelles et habiletés sociales. Affirmation de soi, prise de décision, estime de soi, communication.

Durée/Moment de l'intervention :

Première année : organiser des activités de prévention des toxicomanies avec les jeunes; Deuxième année : mise sur pied d'un guide de prévention des toxicomanies auprès des adolescents. Durée des rencontres : deux à trois heures, parfois davantage.

Modes d'intervention :

Activités de sensibilisation; éducation par les pairs.

Résultats escomptés :

Amélioration des aptitudes personnelles et sociales; réduction de la consommation; pratique de loisirs sains.

Description du programme :

Le guide d'activités est un outil intéressant pour prévenir les comportements à risques associés à la toxicomanie chez les jeunes. Il a été conçu de façon à permettre aux intervenants jeunesse d'agir sur les comportements des jeunes en travaillant notamment sur leurs habiletés à s'affirmer, à communiquer, à prendre des décisions et à s'estimer davantage. La formule qui a été retenue pour atteindre les jeunes est celle de l'éducation par les pairs.

Autres organismes participant :

Quarante-sept maisons de jeunes et/ou d'organismes communautaires jeunesse ont participé à la mise sur pied d'activités préventives en matière de toxicomanie.

Coûts :

40 000 $ de Santé Canada répartis sur deux ans.

Années d'établissement du programme :

1999-2000 : mise sur pied des activités avec les jeunes et les intervenants des organismes communautaires jeunesse et/ou maisons des jeunes; 2000-2001 : réalisation d'un guide d'activités préventives en matière de toxicomanie. Le document compte 208 pages et comprend 15 activités à réaliser avec les jeunes.

Personne-ressource :

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Le Centre Option-Prévention T.V.D.S.
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Town Youth Participation Strategies (TYPS)

Target Population:

Youth in communities of less than 25,000.

Setting:

Community.

Youth Involvement in Program Development or Delivery:

Youth are fully involved in all aspects of development and delivery.

Youth Needs Addressed:

Youths are involved and are listened to, in addressing issues that affect them including substance abuse, suicide prevention, youth rights, education and recreation.

Interventions Used:

Informal learning; social activities; planning skills development; networking resources; social and skill leadership programs; referral services; capacity-building; sustainable planning.

Intended Outcomes:

Adoption of healthy recreational alternatives; Improved awareness of services/help; Improved personal and social skills; Increased access to services; Increased community awareness; Prevent onset/experimentation; Reduced use.

Program Description:

TYPS offers a variety of resources and networking opportunities for youth centres, youth groups, and youth councils to aid in their development of administration, programming, and self-sustainability. Workshops, conferences, manuals and connecting with youth through the TYPS Web page are the primary means we assist youth to learn new skills and resources and share their experiences and information. All initiatives are developed and provided through a participatory action or participatory evaluation approach that ensures youth have a "voice" and a role within their organization and in future TYPS resources.

Contact Time:

Varies; includes workshops, conferences, e-mail and telephone consultations as well as an Internet bulletin board.

Agencies Involved in Program Delivery:

Partnering and multi-disciplinary involvement is a core principle of TYPS. TYPS and associated youth groups routinely partner with youth service providers, addiction counselling agencies, municipal governments, recreational departments, police, health units and health centres, Native Friendship Centres, Health Canada, Ministry of Health, Ministry of Recreation, Citizenship and Culture, and a variety of provincial and national foundations.

Program Costs:

Most of the resource materials are available at no cost or on a cost-recovery basis. Most materials are available free through our Web site. Workshop fees vary from $300 - $1000 per community (depending upon expenses and government subsidies). Annual Conference fee is kept at a minimum through government and foundation funding.

Prevention Principles Most Reflected:

TYPS supports all four principles and their sub-sections listed in the compendium as important components and goals in our program. We concentrate on: building a strong framework; creating an effective process; understanding and involving young people in initial workshops and within the primary resource materials. Striving for accountability is always reviewed and incorporated within the framework of organizational development.

Year Program Established:

1992.

Contact:

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Web site: http://www.typs.com

Youth Web Site Project

Target Population:

Aimed at 9 to 13-year-olds and 14 to 17-year-olds (two different Web sites).

Setting:

Cyberspace.

Youth Involvement in Program Development or Delivery:

Youth provided some consultation and will be involved to a greater degree in the maintenance of the site.

Youth Needs Addressed:

Prevention and some early intervention of substance abuse and problem gambling by providing relevant information on living an addiction-free lifestyle.

Interventions Used:

Informal learning; Awareness events; Resource centre; Adult or older youth mentors; Counselling; Web site (address: www.aadac4kids.com).

Intended Outcomes:

Prevent onset/experimentation; Adoption of healthy recreational alternatives; Improved personal and social skills; Improved relationship with parents; Improved awareness of services/help; Increased access to services; Increased community awareness.

Program Description:

The AADAC4Kids Web site is intended to provide youth age 9-13 with relevant information on drug, alcohol and gambling addictions. It is also intended to help youth explore healthy activities, conduct informal attitude, behaviour and lifestyle assessments and obtain service information in a fun, non-threatening environment. A second site directed toward 14-17-year-olds is slated for development in 2001. In addition to providing information for youth, there are pages dedicated to parents as well as teachers (information and lesson plans) and youth leaders.

Contact Time:

Varies.

Agencies Involved in Program Delivery:

None at present. There are plans to involve Alberta Learning, Children's Services and other relevant government/NGO agencies.

Program Costs:

Still being determined at this time.

Prevention Principles Most Reflected:

Addressing protective risk factors; comprehensive; duration and intensity; based on accurate information; clear and realistic goals; evaluations; sustainable; youth perception; developmentally appropriate; youth involvement; credible messages; knowledge development (some skills); group process (planned); attends to involvement of key influence.

Year Program Established:

2000.

Contact:

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Alcohol, Cannabis and Tobacco Health Promotion for Youth (ACTION)

Target Population:

Students, Grades 1 to 9.

Setting:

School; Family; Combined; Community.

Youth Involvement in Program Development or Delivery:

The program was pilot-tested with youth in the development phase.

Youth Needs Addressed:

Alcohol, cannabis and tobacco are the three most widely used drugs among students in Grades 7, 8 and 9; between the ages of 12-14, youth make decisions that affect health, including whether or not to use alcohol, cannabis and tobacco; research has shown that prevention initiatives targeted at this age group can be effective in delaying the onset and preventing drug use among young people; this program aims to help youth make responsible decisions about drugs.

Interventions Used:

Resource centre; Local media; Awareness events; Informal learning; Social activities; Formal instruction/training; Peer teaching; Adult or older youth mentors; Referrals.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Increased community awareness.

Program Description:

The setting of the interaction combines the home, school and community and is the cornerstone of ACTION; parents should play a significant role in guiding their children and Ontario school teachers are required to cover the subject each year from Grades 1-9; in terms of the overall community, ideally anyone who works with young people from public health nurses to neighbourhood hockey coaches should play a part in drug-use prevention.

An action team of involved community and school members, as well as parents who work together to plan and organize drug education for their youth. ACTION supports the Ontario Curriculum Guide. The ACTION program is available free of charge in English and French, and consists of three parts: 1) a School Kit designed for teachers, school administrators, counsellors, health specialists, non-teaching staff, volunteers and parents - complementing Ontario's Common Curriculum; it includes ideas for student-run and school-wide activities and complete sets of lesson plans; it also suggests ways to involve parents and community groups in drug-use prevention efforts; the kit is for use with Grades 7, 8 and 9 students. 2) a Community Kit designed for public health professionals, health agencies, parent groups and community organizations; it provides a four-step guide to developing and implementing community-based health promotion activities to prevent drug use among youth. 3) a CD-ROM, designed for students containing a series of interactive computer activities that help young people develop

skills and make responsible decisions about drugs; it reinforces the lesson plans in the School Kit in an engaging format. In both the Community and School Kits, worksheets for developing parenting workshops, peer leader training programs and professional development for teachers are presented.

Contact Time:

Most of the lesson plans in the School Kit require at least 40 minutes; time guidelines are indicated on each lesson; for enrichment, extra steps may be suggested; the Community Kit highlights various activities and the degree of time involvement; school and community players can also partner to establish comprehensive strategies.

Agencies Involved in Program Delivery:

Working collaboratively is the cornerstone of this program; the entire program is based on collaborative community action involving schools, parents and the community at large in substance abuse prevention programming for youth.

Program Costs:

Program materials are available in both French and English free of charge to schools and community partners in Ontario; training was provided as well for the first 3 years of the program to selected teams across the province.

Prevention Principles Most Reflected:

- comprehensiveness: through school and community partnerships;
- accurate and balanced information appropriate for the age and developmental stage of the target group - focus on alcohol, cannabis and tobacco as the three major drugs of choice;
- program goals (prevention and delay of onset) are appropriate for this age level;
- program implementation has been monitored throughout the 3-year implementation period;
- sustainability: involving schools as partners from the outset and providing training to existing personnel enhances sustainability beyond the duration of the funding;
- knowledge and skills development are combined in the program content;
- interactive group process is used in the activities;
- training is provided for both the collaborative teams, and for classroom teachers.

Year Program Established:

1997.

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Dallas Society Prevention Services

Target Population:

Children and youth and those that work with them (i.e., school district staff, parents, and community service agency personnel).

Setting:

School; Community.

Youth Involvement in Program Development or Delivery:

Dallas Society Prevention Services advocates for youth involvement in decision-making committees, groups and organizations in the school and general communities; also encourage prevention partners in the Capital Health Region to involve youth in the design, implementation and evaluation of any/all preventive initiatives intended to impact their knowledge, skills development, attitudes and behaviours (i.e., conference planning, grant/project proposal writing and implementation, committees).

Youth Mentoring and Peer Education is an educational strategy used (i.e. offer Advanced Peer Counsellor Training for junior and senior high school students). This advanced training prepares youth that have completed basic Peer Counsellor training to provide basic alcohol/other drug information to other students as well as to serve as youth "prevention partners". Wherever possible, it is arranged that youth take leadership roles in workshops, conferences and special events.

Youth Needs Addressed:

Dallas Society Prevention Services promotes Healthy Child and Adolescent development by using a positive, health promotion approach, where youth is seen as "assets" or valuable community resources. This approach to working with children and youth affords them opportunities to discover and use their "voice" to impact service development and delivery; to acquire and develop valuable interpersonal, group and leadership skills; and, to develop a sense of their potential, power and responsibility for effecting change.

Dallas Society Prevention Services provides consultation, education, and resource services to any community, individual, group or program that is interested in preventing negative, risky behaviours and promoting healthy, thriving behaviours among children and youth. Although we work directly with youth, the largest amount of our time is spent providing information, training and other support services to educators, health professionals, and service staff persons who provide a range of services to children/youth and their families. One of our program goals is to equip and support the adults in the Capital Health Region to strengthen their personal and professional relationships with children and youth so as to support their healthy growth and development.

Dallas Society Prevention Services works directly with School District staff, parents, and community service agency personnel to ensure that prevention/health promotion methods and materials are developmentally appropriate and "child/youth-friendly", i.e. provide a Web site with online resources, consultation and training opportunities: (www.dallassociety.com).

Interventions Used:

Developing activities for students who do not have a substance use problem; planning activities to help school and community personnel cooperate effectively; assisting school personnel to create programs for students at risk of developing substance misuse; assisting teachers in implementing school curriculum, "Learning for Living"; working with evaluation team, to identify characteristics that lead to successful outcomes.

Intended Outcomes:

To increase the age of onset of use of alcohol/other drugs by youth within the Capital Health Region.

To decrease the number of children and youth within the Capital Health Region that experience alcohol and other drug-related problems.

To increase the number of youth within the Capital Health Region choosing to abstain from using alcohol/other drugs.

Program Description:

Theoretic Basis

The DSPS Community-Based Prevention Model draws from and builds upon the work of Uri Bronfenbrenner (adolescent development), Lawrence Green (the Precede-Proceed model), Alfred Bandura (social learning theory), Cheryl Perry (comprehensive prevention model), the School-Based Prevention Program model (BC Ministry of Health), and the Alcohol and Drug Prevention/Treatment Risk Continuum (ARF and AADAC).

Goals

1. Information Provision - Community partners will have access to accurate and consistent alcohol and other drug information and resources.
2. Preventive Initiatives - Prevention partners will implement preventive initiatives throughout the Capital Health Region.
3. Media Liaison - The media will have a heightened sense of awareness with regard to their role in promoting or stopping alcohol and other drug use within the Capital Health Region.
4. Asset Building - Children and youth will possess the necessary developmental assets to make healthy choices concerning their alcohol and other drug use.
5. Family Members - Family members will fill their role as prevention partners.
6. Community Members - Community members will understand and fill their roles as significant prevention partners.
7. Municipal Governments - All fourteen municipal governments (there are 14 of these in the Capital Region) will be informed about Dallas Society Prevention Services and will have a better understanding of how they can contribute to the prevention of alcohol and other drug-related problems.

Dallas Society Prevention Services offers a wide range of community-based and school-based programs, initiatives and services designed to reduce the negative impact of alcohol and other drug use and promote health among children and youth living within the Capital Health Region. In consultation with key community partners we strive to develop comprehensive community prevention plans involving individuals, community groups, businesses, school systems and local media and government. Dallas Society Prevention Services consists of a team of five Community Prevention Coordinators committed to providing high quality, evidence-based preventive services within the Capital Health Region.

"Community-Based Prevention" refers to the development and delivery of comprehensive, evidence-based health promotion and preventive strategies which impact youth, families and other community members. This collaborative approach to prevention is based upon community mobilization and development and builds on individual, family and community assets and strengths.

Services

- Creating customized alcohol- and other drug-related materials for educators to use in the classroom;
- Developing and providing regional and district-wide education, training and resources for the Career and Personal Planning curriculum;
- Collaboration with existing community programs to implement alcohol and other drug prevention strategies;
- Consultation with schools to develop and implement prevention programs and plans;
- Working with parent groups and organizations to deliver alcohol and other drug information and preventive services;
- Linking and working with businesses, community agencies, workplaces, local government, the media, and other community members to determine their role in preventing alcohol -and other drug-related problems and promoting healthy child/youth growth and development.

Contact Time:

Varies.

Agencies Involved in Program Delivery:

Regional Alcohol and Drug Prevention Advisory Committee (RADPAC) was established to ensure that all of Dallas Society Prevention Services' programs and initiatives are based upon the expressed and identified needs of the youth, parents, families, and youth-and-family-service providers living within the Capital Health Region. This advisory group is made up of over 25 community members representing the Ministry for Children and Families, Schools and School Districts, the School District #61 Healthy Schools Program, Ministry of Education, RCMP, Parent Advisory Councils, the Victoria Native Friendship Centre, ICBC, Saltspring Island Community Services, local Parks and Recreation staff, the University of Victoria, and other agencies and

programs. Originally designed as an advisory committee, RADPAC provides DSPS with valuable feedback on program foundations and service delivery. This committee also serves as a way for community organizations interested in alcohol and other drug programs to liaise and share information.

Through regular RADPAC meetings as well as ongoing meetings and contact with individual school districts, schools, parent groups, and a wide variety of youth-and-family service providers, DSPS ensures that our program "Mission", goals, and objectives reflect current issues and concerns in our catchment area.

Program Costs:

Outside of wages, benefits, and some minor materials', travel, and professional development expenses, the Dallas Society Prevention Services program does not have an operating budget. Most of the program expenses are met through partnerships with community "prevention partners" (creative resource-sharing, joint funding proposals, etc.). Other program operating expenses are met by applying for special grants or through honoraria received from the provision of special educational and training events for a variety of target groups.

Fundamental to the program philosophy is the need to work with all stakeholders and partners in our communities to pay for whatever programs, services and special events will allow us to meet our program goals. We believe that more money, new programs, and experts are not always what is required to develop and deliver effective alcohol/other drug prevention programs. We endeavor to work with the resources and assets each of our communities already possess or have access to.

Prevention Principles Most Reflected:

The DSPS program has been developed with all of the Compendium principles or elements in mind. Research into the elements of effective preventive efforts led us to these principles as articulated by prevention researchers and health professionals throughout North America.

Please refer to an article posted on our Web site that references twenty-three (23) "Components of Effective Alcohol and other Drug Prevention Programs and Interventions". This article, titled "*Alcohol and Other Drug Misuse Prevention: New Approaches For A New Millennium*" can be found at www.dallassociety.com.

(To find this article on our Web site, click on "Resources", click on "List of Prevention Articles", then, click on "*Alcohol and Other Drug Misuse Prevention: New Approaches For A New Millennium*".)

Year Program Established:

1991.

Contact:

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Dallas Society Prevention Services
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V8P 2L5
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Aboriginal Shield

Target Population:

Aboriginal youth.

Setting:

Community.

Youth Involvement in Program Development or Delivery:

Via interactive discussion; writing letters to community on their concerns during the program.

Youth Needs Addressed:

To feel pride in heritage; involvement of leaders; elders ensure heritage/culture preservation.

Interventions Used:

Formal instruction/training; Skills from other service providers, i.e. child and family services; promotion of sports/health; training/discussion ideas.

Intended Outcomes:

More accurate understanding of prevalence of drug use; Prevent onset/experimentation; Reduced use.

Program Description:

The aims of the program are: to improve the quality of life for Aboriginal youth; enhance health and safety in Aboriginal communities; improve relationships, promote cultural understanding and mutual respect between police, other service providers and Aboriginal communities. The program delivers drug awareness education/health choices via a culturally sensitive process; designed for Grades 4-8 (most effective in Grades 4-5). Presenters are trained through a 5-day course that addresses needs assessment, cultural awareness, instructional techniques, and addictions knowledge.

Contact Time:

1 hour per week - school session regular class time.

Agencies Involved in Program Delivery:

Akwesasne Child and Family Services; Akwesasne Mohawk Police Services; Akwesasne Drug/Alcohol Prevention services.

Program Costs:

Specialized staff training.

Year Program Established:

1995.

Contact:

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Drug Enforcement Branch - HQ Division
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Web site: http://www.rcmp-grc.gc.ca

Opening Doors

Target Population:

Selected; at-risk youth in their transition years (usually implemented in Grade 9, but relevant to Grades 8-10).

Setting:

School/Family/Community.

Youth Involvement in Program Development or Delivery:

The program was piloted with youth on several occasions before the final version was completed.

Youth Needs Addressed:

Youth at risk of developing problem behaviours, such as school truancy, school drop-out, alcohol and/or drug use, violence and other anti-social behaviours.

Interventions Used:

Informal learning; Resource centre; Peer counselling/referrals; Counselling; Awareness events; Formal instruction/training.

Intended Outcomes:

Prevent Use/Experimentation; Reduced Use; Adoption of healthy recreational alternatives; Improved personal and social skills; More accurate understanding of prevalence of drug use; Improved relationship with parents; Improved awareness of services/help; Increased community awareness.

Program Description:

Comprehensive prevention program designed to identify and assist grade 9 students who may be "at risk" of developing social problems such as school truancy, school drop-out, alcohol and/or drug use, violence and other anti-social behaviours. Program components are: 1) initial screening and student selection; 2) student program; 3) parent program; 4) staff awareness leader training. The student program is highly interactive and facilitated by a leader from a community agency and a staff person from the school (usually guidance or social work staff, as opposed to a classroom teacher). The program is run in small groups with only 10-12 students selected per school.

Contact Time with Participants:

Students participate in 17 in-school sessions (length varies from 1 to 2 hours). Parent Program is 5 sessions in length (1 to 2 hours per session).

Other Agencies Involved in Program Delivery:

Youth agencies (i.e. counselling agency; public health units) and schools.

Program Costs:

Current costs to school and community agency: Opening Doors kit (student and parent leader manuals, promotional video, information booklets for parents) approximately $65; $100 per person for leader training; approximately $200 per school required to purchase resource materials for student and parent sessions. Screening program is currently under revision to enable schools to do on-site screening. Software will be included in the revised kit and costs will be adjusted accordingly. Materials are available in both English and French.

Prevention Principles Most Reflected:

Address protective and risk factors; seek comprehensiveness; ensure program duration and intensity; base program on accurate information; use interactive group process.

Year Program Established:

1993-94: Research Study (see description in Section C);
1997: Implementation across Ontario.

Contact:

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Student Assistance for Everyone (SAFE)

Target Population:

Universal; selective.

Setting:

School.

Youth Involvement in Program Development or Delivery:

The SAFE program is designed to assist in providing a healthy learning environment for students. Students who are seeking assistance from this program are able to contact the School Counsellor so they can access either the prevention or intervention services as appropriate. There are referral procedures in place for both staff and parents, should they have concerns regarding a student.

Youth Needs Addressed:

Promotion of health and wellness through preventive strategies and interventions. Case conferencing with students, family and school staff to generate solutions to issues and concerns.

Interventions Used:

In terms of addressing social issues that are targeted in the school, a curriculum has been developed that focuses on a number of prevention presentations and workshops, which are delivered by the members of the SAFE team. These presentations include FAS/E awareness, anger management, overview of substances, overview of gambling issues, relationship issues, date rape, etc. Formal instruction/training; Informal learning; Awareness events; Referrals; Adult or older youth mentors; Social activities; Counselling.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Adoption of healthy recreational alternatives; Improved personal and social skills; More accurate understanding of prevalence of drug use; Improved relationship with parents; Improved awareness of services/help; Increased access to services; Increased community awareness; Improved substance-related policies in schools, health, social, police services.

Program Description:

SAFE is a program designed to help provide a healthy learning environment for students in school. This program is made up of a team of professionals who consist of school staff and community members who pool their expertise and work together to help students and their families. The SAFE program is also committed to offering preventive services such as awareness campaigns, presentations and workshops to students, parents and/or teachers on a variety of issues and topics.

Contact Time:

Initially the SAFE curriculum addressed all Grade 8, 9, 10 and 11 students through a series of classroom presentations and workshops. The program will be included in the curriculum for all elementary schools for the 2000/2001 school year.

Agencies Involved in Program Delivery:

Edwin Parr Community School; Boyle School; Children's Services; Mental Health; Family and Community Support Services; Justice; Ministerial Association; Youth Workers.

Program Costs:

This particular program has been implemented without the need for funding. School staff and agency representatives have committed staff resources to this program as it aids them in providing their services to the students, families and school in a proactive and efficient manner.

Prevention Principles Most Reflected:

Build a strong framework; create an effective process; understand and involve young people.

Year Program Established:

1995.

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Families and Schools Together (F&ST)

Target Population:

"At risk" children between the ages of 4 and 9 and their families (includes siblings of all ages).

Setting:

School; family; community.

Youth Involvement in Program Development or Delivery:

Youth were not involved. Program is a replicated one where teams are trained. Parents participate in the delivery of the program.

Youth Needs Addressed:

Develop and strengthen resiliency in children. Support parents in becoming the primary preventive agent for their children.

Interventions Used:

Informal learning; Social activities; Buddy system; Self-help Groups; Referrals; Awareness events.

Intended Outcomes:

Prevent onset/experimentation; Adoption of healthy recreational alternatives; Improved relationship with parents; Improved personal and social skills; Improved awareness of services/help; Increased access to services.

Program Description:

Families and Schools Together links all of the systems that impact on a child's life: family, school, peers and community. The main goal of the program is to strengthen the child's bond with parent(s) and to develop a positive connection between family, school and community. The start up of the program involves eight weekly multi-family meetings, which are held at school. For two and one half hours, families participate in structured, positive activities that are based on current preventive literature and research and facilitated by a collaborative team. After graduating from the eight-week program, families continue to meet on a monthly basis for two years. FASTWORKS follow-up groups focus on reinforcing the positive gains made during the eight weekly sessions, strengthening support networks and providing opportunities for increased community participation and leadership development.

Contact Time:

Eight week sessions (for 2 1/2 hrs. each week); 2 yr. follow-up (meet once a month - approx. 2-3 hrs. per meeting).

Agencies Involved in Program Delivery:

Peel District School Board; Peel Health Dept.; Parents; Centre for Addiction & Mental Health; YMCA-Youth Substance Abuse Program; Peel Addiction, Assessment & Referral Center.

Program Costs:

The direct costs cited here are for one school year (they do not include staffing, travel expenses, and parent partner honouraria):

- Training costs: $6,000 (includes 3 full days of training and trainer site visits, training materials, evaluation analysis and a written report);
- Program materials: $2,000 (for two 8-week cycles);
- FASTWORKS: $1,200.

Prevention Principles Most Reflected:

1. Build a strong framework: Families and Schools Together directly addresses those factors that pose the most risk to children. It engages a collaborative team that builds on community partnerships. The FASTWORKS component of the program maintains a long-term relationship with the families, providing ongoing positive activities and opportunities.
2. Strive for accountability: Families and Schools Together has a strong research component that relates directly back to its program goals. There is a national centre that analyzes all the Families and Schools Together evaluation data. In this way, teams can assess whether their outcomes are consistent with the standard and expected outcomes realized by other Families and Schools Together teams. Family Service Canada and Family Service Ontario have been providing national and provincial support respectively to the issue of sustainability of the program. (See Section C for description of research study of FAST program, on which F&ST is based).
3. Create an effective process: Parents respond to the underlying values and messages of Families and Schools Together. The two messages that particularly resonate with parents are: 1) parents are the best preventive agents for their children and 2) all parents love and want what is best for their children. These affirming messages are particularly important for many parents who may feel disempowered in their parenting and perhaps in their lives.

Families and Schools Together is spoken of as a program, but in fact it is a process where families, school staff and community members, through structured activities, experience each other differently. Parents are given the opportunity to be in a leadership role and team members are trained to engage parents in ways that are respectful, empowering and relaxed.

Year Program Established:

1997.

Contact:

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Nobody's Perfect

Target Population:

For parents of children from birth to age five.

Setting:

Community; Family; School.

Youth Involvement in Program Development or Delivery:

Parents were involved in the development of the program and the pilot testing in early 1980. All participants provide feedback about the program at the end.

Youth Needs Addressed:

Reduce isolation, build support and confidence, increase knowledge of child development, health and safety, and increase knowledge about adult issues that affect family life.

Interventions Used:

Informal learning; Resource centre; Peer teaching; Drop-in centre; Social activities; Self-help Groups; Referrals.

Intended Outcomes:

Improved personal and social skills; Improved awareness of services/help; Increased access to services; Increased community awareness.

Program Description:

Nobody's Perfect is a parenting education and support program for parents of children from birth to age five; it is designed to meet the needs of parents who are young, single, socially or geographically isolated, or who have low income/limited formal education; participation is volumtary and free of charge; the program is not intended for families in crisis.

Contact Time:

Varies on the program.

Agencies Involved in Program Delivery:

Federal Government, Provincial/Territorial Governments, Municipal Governments, Private Donors, Services Clubs, Volunteers, Foundations, Private Businesses, Community Organizations.

Program Costs:

Program materials are available in both French and English. Program costs include facilitators' time, childcare, parent materials, refreshments and transportation. Training is often provided free or at low cost. Depending on circumstances, costs for eight weekly sessions could range from $1000-$1500.

Prevention Principles Most Reflected:

Effective process; combine knowledge and skills development; use interactive group process; give attention to leader qualities and training.

Year Program Established:

Since mid 1980's in Atlantic Canada; since 1988 in the rest of Canada.

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Ready or Not

Target Population:

Parents of children ranging in age from 8 to 12-13 years.

Setting:

Family; School.

Youth Involvement in Program Development or Delivery:

Parents were involved in development.

Youth Needs Addressed:

Problem solving; decision making; learning assertive refusal skills; building self-esteem; communication skills.

Interventions Used:

Formal instruction/training; Informal learning; Resource Centre; Telephone info line; Counselling; Informal parent-sharing (support information sessions).

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Improved personal and social skills; Improved relationship with parents.

Program Description:

The overall goal of Ready or Not is to decrease the number of teens using/abusing drugs/alcohol. Other goals a~e: enhance parent/child communication (into the teen years); increase parents' self-esteem, self-confidence as parents; encourage self-help and mutual support among parents; provide information on "gateway" drugs (i.e., alcohol, tobacco, marijuana, inhalants). Program involves a large amount of role-playing and interactive learning.

Contact Time:

Each series is 6 sessions; 2 hours each week; 4 to 6 series a year.

Agencies Involved in Program Delivery:

Childcare Algoma; Children's and Society Learning Disability Association; Sault Ste. Marie Area Hospitals; City Police; local RCMP; Centre for Addiction and Mental Health.

Program Costs:

Program materials are available in both French and English. Minimal cost to run program: some volunteer phone calls, purchase of coffee/tea/snacks; there is a cost if a training session for facilitators is set up, though it varies depending on location of training from $500 to $1,000.

Prevention Principles Most Reflected:

Strive for accountability: Canadian survey done on what parents want most in education program to help prevent drug abuse resulted in the program covering four key areas: a) communication skills; b) discipline; c) drug info; d) self-esteem. As well: build a strong framework (all points covered); strive for accountability; create an effective process (all points covered).

Year Program Established:

1995 (at this particular site). Nationally, Health Canada funded initial implementation, but does so no longer. Among others continuing to use the program in recent years are the B.C. Council for Families (contact Mark Tasaka (604) 660-0675) and Family Services of Regina.

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Alternatives for Youth

Target Population:

Youth ages 14-25 and their families.

Setting:

Combined; Community; Family; School; Street.

Youth Involvement in Program Development or Delivery:

Youth are involved as advisory members and in the pilot sites.

Youth Needs Addressed:

Issues related to substance use.

Interventions Used:

Formal instruction/training; Informal learning; Awareness events; Resource centre; Telephone info line; Peer teaching; Peer counselling/referrals; Social activities; Counselling; Web site; Family education program; Client directed counselling services.

Intended Outcomes:

Reduced use; Adoption of healthy recreational alternatives; More accurate understanding of prevalence of drug use; Improved personal and social skills; Improved relationship with parents; Improved awareness of services/help; Increased access to services; Improved substance-related policies in schools, health, social, police services.

Program Description:

The goal is to support, guide, educate and encourage youth and families in achieving and maintaining a lifestyle that does not include the abuse of substances, and supports being a positive contributor to their community. The activities include community treatment and follow-up, outreach and harm reduction strategies, and educational and community development programs. All programs are interrelated in partnerships with other agencies/services.

Contact Time:

Educational programs are varied in length; clinical sessions are client directed. Our program utilizes structured interview and feedback sessions.

Agencies Involved in Program Delivery:

School boards; Addictions Assessment Services; CAS; Public Health Units; Probation and parole, etc.

Program Costs:

Costs are by program and include direct (i.e. salaries, etc.), material and administrative costs for the following three programs: (1) community treatment / follow-up ($99,551); (2) outreach / harm reduction ($116,560); and (3) education / community development ($46,560). Further breakdown is available.

Prevention Principles Most Reflected:

Understand and involve young people; create an effective process; strive for accountability.

Year Program Established:

1989.

Contact:

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Web site: http://www.teens-drugs.org

Harm Reduction for Rural Youth

Target Population:

Students Grade 9 - 13 at Dunnville Secondary School.

Setting:

Community; School.

Youth Involvement in Program Development or Delivery:

Co-op students led the project, including developing and conducting a needs assessment with 340 students in their secondary school (three co-op terms involving three students each term). The students designed and wrote a magazine for their peers; end users of magazine consulted about title and content.

Youth Needs Addressed:

Harm related to alcohol and other drug use in rural community.

Interventions Used:

Awareness events; Resource center; Product development (magazine and "how to" manual for others to replicate process).

Intended Outcomes:

Reduced use; Improved personal and social skills; Improved awareness of services/help; More accurate understanding of prevalence of drug use.

Program Description:

The goal of the Harm Reduction for Rural Youth Project was to inform young people about harm reduction in relation to the use of alcohol and other drugs. Youth members of the project team were actively involved in issues that were of concern to them and in developing a magazine to educate their peers. Youth members received training in conducting a needs assessment, and implemented a survey throughout their secondary school. The survey indicated the issues that youth wanted to know about, as well as the mechanism for learning about the issues (in this case, they chose a magazine). The magazine includes factual information about alcohol and other drugs, as well as tips for safe use.

Contact Time:

Varies.

Agencies Involved in Program Delivery:

Addictions Division, Haldimand-Norfolk Regional Health Unit; Centre for Addiction and Mental Health, Dunnville Secondary School Cooperative Education Department and Administration; The Dunnville Chronicle (Community newspaper); Children's Aid Society.

Program Costs:

$5,000 over 3 years for student placement support and development/production of 1500 magazines. $10,000 for development and production of "Freedom to Act: the Harm Reduction for Rural Youth Project".©2000 Centre for Addiction and Mental Health. The "Freedom to Act" handbook is available in both English and French at a cost of $19.95 in Ontario and $24.95 outside of Ontario.

Prevention Principles Most Reflected:

Understand and involve young people; create an effective process.

Year Program Established:

1997.

Contact:

Local implementation:

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Harm Reduction for Rural Youth
Haldimand-Norfolk Regional Health Department
Dunnville, ON
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Program materials:

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Healthy Choices for Our Children

Target Population:

Children, teens and their parents.

Setting:

Community.

Youth Involvement in Program Development or Delivery:

Youth are actively involved in planning their program (i.e., planning activities, setting goals, making decisions) through a process of shared decision-making.

Youth Needs Addressed:

Need to feel competent and confident.

Interventions Used:

Web site; Informal learning; Social activities; Adult or older youth mentors; Drop-in centre; Adventure alternatives; Volunteering in the community.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Adoption of healthy recreational alternatives; More accurate understanding of prevalence of drug use; Improved personal and social skills; Improved relationship with parents; Improved awareness of services/help; Increased access to services; Increased community awareness; Improved substance-related policies in schools, health, social, police services.

Program Description:

Healthy Choices is a personal development program for young people at risk of substance abuse, in particular solvent abuse. It is a mentorship program where an adult role model works with a limited number of young people to support their growth and engage them in positive non-school activities. The program is youth driven in the sense that participants are actively involved in planning their own volunteer work, outings and recreation activities.

Goals and activities

Increase: involvement in positive non-school activities; a sense of belonging; opportunities for achievement and success; opportunities for youth to contribute to their communities; opportunities for youth to assume responsibilities; self-esteem.

Goals are achieved through a variety of activities that include:

Goal setting activities; volunteer work in the club and wider community; active recreation; social outings; cultural activities; regular interaction with a supportive and knowledgeable adult; linking youth with new activities and experiences; rewarding positive choices and participation through special outings, events and shopping stipends; and extra support for the child's family.

There are five main elements to the Healthy Choices Program:

1. Adult Mentor: this is facilitated by a staff member in the club, who acts as a coach and guide for participants. The program allows the staff person to provide individual support and attention to members who need it. The small group setting fosters the building of relationships and a program that responds to the interests of youth. At all times, staff act as appropriate role models for youth.
2. Youth are Actively Involved in Planning Program: programs are more successful and have a bigger impact when youth are actively involved in planning activities, setting goals, and making decisions. A process of shared planning and decision-making contributes to the participant's sense of importance, competence and confidence. It also ensures that the program responds to the interests of participants.
3. Volunteer Work in the Club and Wider Community: work can be a positive, structuring force in the lives of youth and is itself a developmental activity. Through community service work, young people make visible and valuable contributions to their club and their community. This contribution engenders feelings of achievement, competence, pride, belonging and connectedness with the wider community. Work challenges young people to stretch themselves, try new things, get along with others, develop personal skills and assume responsibility.
4. Skill Building: The program emphasizes the development of new skills and trying new things. Staff must ensure that children understand that one of their responsibilities for being in the program is a commitment to trying new things and learning new skills (i.e., guitar lessons, sports camp, magic, martial arts, making a Web site, etc.). The program also builds practical social skills and life skills through volunteer work, recreation, and goal setting exercises.
5. Recreation: physical and social recreation is used to build skills, engender a sense of belonging, prompt discussions, and reward participants for their achievements. Participants are actively involved in choosing their recreation activities.

Contact Time:

Varies.

Agencies Involved in Program Delivery:

Those that youth volunteer with.

Prevention Principles Most Reflected:

Involving youth in program design and implementation; giving attention to leader qualities and training.

Contact:

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Let 'Em Go: The Street Involved Youth Harm Reduction Experience

Target Population:

Indicated. Let 'Em Go is a resource for youth service providers, or peer leaders that provides information on coordinating a youth driven project. The accompanying video "Safer with CYPHER" was developed by street involved youth for their peers, the majority of whom are already involved in drug use.

Setting:

Community; Street.

Extent of Youth Involvement in Development and Delivery of Program:

A team of six street involved youth, researched and developed a video: Safer with CYPHR. They also conducted a needs assessment survey with approximately 60 street-involved youth.

Youth Needs Addressed:

Harm reduction related to drug use and street life, and youth involvement and empowerment.

Interventions Used:

Resource centre; Local media; Awareness events; Informal learning; Formal instruction/training; Peer teaching; Research, Product development (video).

Intended Outcomes:

Reduced use; adopt healthy alternatives; improved personal and social skills; increased community awareness; improved substance-related policies; health, social, police services; safer drug use; awareness of harm reduction approaches; youth involvement and empowerment; work skills; self esteem.

Program Description:

The goals of the Street Involved Youth Project were to involve youth in the research and development of an educational program; to empower marginalized youth; and to increase awareness of harm reduction approaches. Let 'Em Go is a manual that presents practical information for service providers or coalitions on approaches used in the Street Involved Youth Harm Reduction Project and the results of the evaluation. The Safer with CYPHR video, which is targeted at the youth themselves, explores the risks and realities of street life and suggests ways to reduce drug related harm.

Contact Time:

A youth team and coordinator worked 2 half days per week for a period of 8 weeks to research and develop the video.

Agencies Involved in Delivering Program:

Street youth agencies in Toronto; Coalition Of Agencies Serving Downtown Youth.

Program Costs:

Original program development costs included salary for youth coordinator, honoraria for the youth on the project team, research support, and production costs for the video which totaled approximately $50,000. The manual and video are currently available in Ontario in both English and French at a cost of $24.95 and $49.95 respectively. Outside of Ontario, the costs are $29.95 and $59.95.

Prevention Principles Most Reflected:

Recognize youth perceptions of substance use; Involves youth in design and implementation; Combines knowledge and skills development; Empowers marginalized groups; Promotes harm reduction approaches.

Year Program Established:

1998.

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Project Y.O.U (Youth of Unity) Glue-Sniffing Awareness Project

Target Population:

Youth ages 10–18.

Setting:

Combined: School and community.

Youth Involvement In Program Development or Delivery:

Extensive involvement. Post-secondary school youth were involved in the first community consultations, formed part of the planning group, were hired to outreach to local schools and then to train youth from high schools and middle schools for delivery of the project to middle school youth. Middle school youth were involved in the early stages in a focus group to develop a list of strategies to get prevention messages across to same-age peers.

Youth Needs Addressed:

Original impetus came from observation of several glue-sniffing episodes among youth ages 8 -12 around a community centre by Parks and Recreation staff. As well, numerous glue tubes were found in the community centre grounds and the local school grounds. A community consultation followed, and a planning group was formed. Several approaches were identified including peer education around the risks associated with glue sniffing. A focus group was held with the target age (middle school youth) and a list of effective ways of getting health messages to this age group was developed. Outreach followed to high school and middle school youth to plan the intervention. Feedback from youth indicated that a new name was needed and Project Y.O.U (Youth of Unity) was born. The project is now being promoted under this name.

Feedback from the intervention has led to changes for this coming year, including honoraria for the youth involved.

Interventions Used:

Awareness events, informal learning (at community consultations, agency training event and advisory committee meetings), formal training, peer teaching, adult or older youth mentors, alternatives identified.

Intended Outcomes:

More accurate understanding of prevalence of drug use, improved personal and social skills, improved awareness of services/help, increased community awareness, improved substance-related policies and practices in place in recreational setting.

The coalition of committed partnerships provided solidarity and support for the development and implementation of this project. The project provided a timely response to glue sniffing among youth in Grades 6, 7 and 8. High school students were able to provide a challenging, yet supportive mentorship role that allowed drug use to be discussed. Youth Coordinators increased their own profile in the community as leaders and advocates for the voice of youth

Because of the involvement of the area schools and community members, the issue of glue sniffing has become more known generally.

Program Description:

Mission

To reduce glue sniffing among youth in the Jane-Finch Community.

Goals

To enhance the existing protective factors of community organization, youth leadership skills and social supports from non-family networks in the community.

Objectives

In partnership with community volunteers, local schools and community agencies, this project aims to build community protective factors in a number of ways:

1. To increase and support a social network with youth in the community from non-family members. Activities to meet this objective included:
   - peer mentorship activities for older youth (ages 13-18) worked with younger youth (ages 10-12) to establish glue-sniffing awareness and prevention messages;
   - the youth also worked together to develop the medium for these messages, (whole school presentations, classroom presentations);
   - volunteer recognition event was held at the end of the project with additional mentors being identified (local business people, police etc.) who could contribute to youth activities and support in an on-going way.
2. To increase community organization around this issue. Activities to meet this objective included:
   - an advisory committee made up of health, social and recreational service providers who work in the neighbourhood who had substance abuse prevention as part of their on-going mandate;
   - the advisory committee also has members from larger organizations capable of providing administrative support, as well as links with resources beyond the neighbourhood. These organizations also have substance abuse prevention as part of their central mandate;
   - community consultations with stakeholders, parents and cultural associations;
   - development of printed resources to alert parents to glue-sniffing, and ways to seek help. These resources were developed with literacy needs in mind;
   - one of the partners in the advisory committee worked with other members to develop a policy and a response strategy for that agency. A training event about the new policy and response strategy was held with staff of that agency.

3. To increase leadership skills in local youth. Activities to meet this objective included:
   - local youth contributed to the planning and delivery of the presentation;
   - outreach, which builds on existing peer leadership classes at high schools and youth advisory councils at local agencies;
   - Youth Coordinators' own development which included: development of a project proposal, meeting with potential facilitators of creative programs, connecting with a celebrity who delivered a motivational segment to the presentation, connecting with both schools and several layers of administration, and outlining the five phases of the program (development of an information package, networking and negotiation of partnership with local schools, recruitment drive, development of intervention and the presentation of skits, concluding with the volunteer recognition night).

Contact Time:

The two Youth Coordinators met with high school youth in four sessions to build rapport, to increase knowledge about glue sniffing and to build skills around working with younger peers in delivery of the intervention.

They also met with the middle school participants over 4 weeks for the same objectives, then the two groups were brought together to plan the final approach which was a series of skits about a middle school youth and the difficulties he runs into when he sniffs glue. The presentation identified alternative community activities available to youth other than sniffing glue as well as community resources if someone was sniffing glue.

Other Types of Agencies Involved in Delivering Program:

Neighbourhood

- Youth Clinical Services, an educational and counselling service for the prevention of and treatment for problems associated with substance use;
- Jane Finch Community and Family Services, a multi-faceted support agency with links to ethnospecific groups. It also sponsors the Black Creek FOCUS Project which has a mandate to prevent problems, including injuries, associated with alcohol and other drug use;
- Driftwood Community Centre, a Parks and Recreation facility which provides recreational, sport and educational programs and supports to the community;
- Public Health Nurse, with Toronto Public Health, North region, who provides links with local schools as well as support for comprehensive school health programming and community capacity building;
- Agape Community Ministry, which provided support and youth volunteer co-ordination in the first year of the project;
- Two local schools with the Toronto District School Board (secondary and middle schools) and two local schools with the Toronto Catholic District School Board (secondary and elementary).

City-wide (or larger) Agencies

- Hospital for Sick Children, Substance Abuse Program;
- Centre for Addiction and Mental Health, Communications, Education and Community Health;
- Pat Sanagan Consulting, Drug Education and Training.

Program Costs:

Budget received from Drug Abuse Prevention Program City Grants:

Year 1 (1999 – 2000)	$6,570
Year 2 (2000 - 2001)	$8,020

Year 1 Costs include:	
Project materials and supplies	$750
Honoraria	$800
Workshop/Forum expenses	$700
Local travel Expenses	$200
Salaries (2 youth coordinators for 5 hours a week each for 25 weeks)	$3,750

Year 2 Costs include these costs plus:	
Advertising and promotion	$250
Honorariums increased to	$1,220
Workshops/Forums increased to	$1,000
Local travel expenses increased to	$680
10% administration fee for benefits	$370

Year Program Established:

1998.

Prevention Principles Most Reflected:

The three prevention principles most fully reflected are: addressing protective factors; seeking comprehensiveness including policy development; involving youth in program design and implementation.

Contact:

Youth Clinical Services
Contact person: Winston Fleming Smikle
Address: 3451A Weston Rd., Toronto, ON M9M 2V9
Tel: (416) 742-2514 x 232
Fax: (416) 742-5855
Email: WinstonF@youthclinicalservices.org

Saskatoon Downtown Youth Centre/EGADZ

Target Population:

At risk youth; 12 to 19 years.

Setting:

Community; Street.

Youth Involvement in Program Development or Delivery:

Youth provide input and ideas for programs and services through group and individual feedback or involvement. Feedback is most often provided in an informal manner.

Youth Needs Addressed:

Pregnancy counselling, information and support, parent education, individual counselling and referrals, addictions, educational support, employment, housing, legal issues, nutrition, recreation.

Interventions Used:

Formal instruction/training; Informal learning; Awareness events; Resource centre; Adult or older youth mentors; Drop-in centre; Social activities; Counselling; Self-help groups; Referrals; Local media; Assessment and referrals to other services as needed (e.g., treatment centres, outpatient services).

Intended Outcomes:

Reduced use; Adoption of healthy recreational alternatives, Improved personal and social skills; Improved relationship with parents; Improved awareness of services/help; Increased access to services; Increased community awareness; Improved substance-related policies in schools, health, social, police services.

Program Description:

The mission of the Saskatoon Downtown Youth Centre, Inc (EGADZ) is to encourage youth "at risk" in the city of Saskatoon to make choices that improve their quality of life through the provision of direct services using an interagency approach. This is accomplished through a number of programs and services, including:

EGADZ Drop In: a variety of life skills, recreation and educational programs are available on a voluntary basis. Shower, laundry, supper and a clothing depot are available.

EGADZ Teen Parenting Program: offers structured classes for young parents to learn or enhance parenting skills that will benefit themselves and their children. One on one counselling, advocacy and referral service is also offered.

EGADZ Day Support Program: operates with the objective of providing stability, structure and support to youth in preparation to re-enter the educational system. It is offered 5 days a week for youth that cannot attend a regular school program for various reasons and includes lifeskills, recreation, literacy and volunteer activities.

EGADZ Street Outreach: operates through a van four nights and two evenings a week. Outreach staff also provide follow up service during the day such as assessments and referrals to detox or treatment. Outreach workers are available to provide assistance and support to the youth in other areas of their lives. The overall intent is to encourage and assist youth involved in street lifestyles to seek out more healthy, safe and productive lives.

EGADZ Back to School Program: provides structure and stability to youth experiencing difficulty integrating or maintaining their school placements.

EGADZ Explorers Group: provides additional support for young women who have been involved or are at risk of being sexually exploited by johns or pimps through prostitution.

Jump Start: provides pre-employment readiness training, which is 6 months in duration and includes a 5 week work placement.

My Home: is a housing project in partnership with other agencies for youth that have made a decision to leave their street lifestyle(s).

Other programs are the HYPE newsletter produced by the youth and Joe's Garage that is a program for boys aimed at curbing unacceptable behaviours.

Contact Time:

Varies with individual youth and within individual programs offered at the Centre.

Agencies Involved in Program Delivery:

Represented on the board of directors are the Department of Social Services; Saskatoon District Health - Mental Health Services; Saskatoon City Police; Friendship Inn; Indian and Metis Friendship Centre, Federation of Saskatchewan Indian Nations; Saskatoon Tribal Council; Addictions Services; Public Health Services; City of Saskatoon; Catholic School Board; Public School Board; YMCA; Inner City Council of Churches. The program also has support from the Healthy Mother, Healthy Baby Program, the Library project with READ Saskatoon and Saskatoon Public Library.

Program Costs:

The Teen Parenting Program is supported by Health Canada as a Community Action Program for Children (CAPC) Project. The funding for the 2000/2001 fiscal year is $61,959. Funding for the other programs within EGADZ comes from other sources.

Prevention Principles Most Reflected:

Youth are masters of their destiny. They will be treated with dignity and respect. They will not be judged. They will be supported and encouraged to make the necessary life style changes to allow them to become contributing, productive members within their community.

Year Program Established:

EGADZ was established in 1990. The Teen Parenting Program began in 1995.

Contact:

Ms. Mavis McPhee
Saskatoon Downtown Youth Centre/EGADZ
Teen Parenting Program
301-1st Avenue North
Saskatoon, SK S7K 1X5
Tel: (306) 931-6644
Fax: (306) 665-1344
Email: egadz.tpp@sk.sympatico.ca

Teen Touch Inc. Helpline

Target Population:

All youth and their caregivers in Manitoba.

Setting:

Community.

Youth Involvement in Program Development or Delivery:

The service was designed by youth. They define the needs of the program.

Youth Needs Addressed:

Trained volunteers answer calls about any issue from youth, parents, teachers, young adults.

Interventions Used:

Formal instruction/training; Informal learning; Awareness events; Resource centre; Crisis line; Counselling; Referrals; Local media; Web site; Volunteer activities; School presentations; Mall displays; Peer support group training.

Intended Outcomes:

Prevent onset/experimentation; Reduced use; Adoption of healthy recreational alternatives; Improved personal and social skills; Improved relationship with parents; Increased access to services; Improved awareness of services/help; Increased community awareness.

Program Description:

This is a volunteer-operated 24-hour helpline for Manitoba youth and their families. We provide non-judgmental, confidential and anonymous telephone support by actively problem-solving with youth. We provide resources and refer callers to organizations offering services that fit their needs.

Contact Time:

Telephone helpline service available 24 hours a day, every day of the year.

Agencies Involved in Program Delivery:

Every social agency in Manitoba is a partner by virtue of the fact that we refer many callers to their services. Every school posts Teen Touch posters (900 schools) - as do police and RCMP, recreational centres, community clubs, clinics, etc.

Program Costs:

Teen Touch operates on a shoestring budget of under $200,000 annually. Our entire budget is directed to operating and maintaining the Helpline.

Prevention Principles Most Reflected:

Empowerment is our one word goal - to teach youth tools of problem-solving on all levels. We promote our line using the phrase "any problem is a real problem" to encourage youth to call before their concerns escalate into a crisis situation.

Year Program Established:

1983.

Contact:

Ms. Alison Ariss
Teen Touch Inc.
Telephone Distress Line
210 - 800 Portage Ave.
Winnipeg, MB R3C 0N4
Tel: (204) 945-5467; (204) 783-1116 (24 hour distress line)
1 (800) 563-8336 (Outside Winnipeg)
Fax: (204) 945-5565
Email: teentouch@pangea.ca
Web site: http://www.teentouch.org

Youth Substance Abuse and Parent Programs

Target Population:

Young drug users, parents, and siblings. Young drug users, ages 11 to 22, and their parents and siblings. Some of the clients are currently using and some are in recent recovery. A number of clients are marginally housed: they have a room at home, but also live on the street for part of the time.

Setting:

Community (agency); School.

Program Description:

Theoretic Basis

Stages of Change model targeted to Stages of Treatment. Harm reduction to abstinence continuum; Family system intervention; Motivational interviewing; Co-dependence theories; Concurrent diagnosis theories.

General Description

The program approach is based on a harm reduction to abstinence continuum. This approach is seen as being crucial for engaging youth. Abstinence is not required, but is the ideal goal. Reducing risk and increasing protective factors are key strategies. The Stages of Change model is also used and matched with stages in treatment. The Youth Substance Abuse and Parent Programs offer services on an outpatient basis in the agency and through partnerships with schools and community agencies. A day program is offered through a home for pregnant teens and new mothers. The target groups include youth who abuse substances and inject drugs, and their parents and siblings. The Youth Substance Abuse Program takes a systems approach and includes individual and group counselling, as well as close contact with allied agencies. Separate services for adolescents (11-18) and young adults (19-23) are provided. The program for parents includes information, education, and counselling. Training for health, mental health, education, probation and other agencies is also provided.

Components

Youth Substance Abuse Program: the Program takes a systems approach, and includes individual counselling, group counselling and partnering with schools, government and community agencies. Engagement is the first, key strategy in the program. The focus during the first contact with the client is to talk about the person, not the drug use, and the goal is to build trust. Abstinence during the first contact is not seen as suitable goal, however a priority of the program is to try to get youth off needles as soon as possible. Information is provided on safer sex and safer drug use as well as safer needle use.

Once the client is engaged, the next step is assessment, and building motivation to continue in the program. Individual counselling continues to be used during this stage, and the role of alcohol and drug use is discussed as part of the assessment. Motivational counselling involves discussing goals for change in alcohol and drug use, as well as in other life areas.

As the client moves through the program, group counselling is used in addition to ongoing individual counselling. Problem solving and relapse prevention are addressed. A key part of the program is to work together with other agencies so that the client has at least one contact a day from an agency worker from Rideauwood or other service collaborators.

A large percentage of the youth in the program have dual disorders (learning disorders or mental illness in addition to substance abuse). In the Youth Substance Abuse Program, the substance abuse issues are dealt with at the same time as the mental health issues.

Parent Program: parents are seen as effective allies potentially, most of the time, and a key strategy is to work with parents whenever possible. Youth are encouraged to engage parents to attend the Parent Program. (If youth see their parents are attending the Parent Program and working on their own issues then youth see this as a gesture of caring.) The Parent Program includes information sessions, education, individual counselling, group counselling, family and couples counselling and issues including addiction, family and parenting skills.

Messages

- Engagement - talk about the kids and what is hurting them, not the drug use.
- Earn client's trust first. Don't push abstinence - massage it in over time;
- Focus on abstinence for full treatment, but not during the first contact or for the first few months;
- Do not make abstinence mandatory, but rather desirable;
- Take the time that it takes to deal with the issues that need to be addressed. Do not be wedded to a structured program length;
- Don't blame parents: help parents, and work with them whenever possible;
- Don't label kids; be careful about using the word addict;
- Give kids unconditional respect and care, even when faced with unpleasant behaviour (violence not included);
- Make sure the kids know they can always come back into the program;
- The program should feel respectful and safe for kids.

Knowledge and Skills Developed

Assertiveness skills. Self esteem skills. Self-protection skills such as refusal, avoiding violent relationships. Anger management. Relapse prevention. Problem solving. Positive social networking. Emotional IQ dealing with trauma.

Means of Reaching Individuals Involved in Injection Drug Use

Clients are reached through referrals from other agencies. Rideauwood works with the agencies that do outreach, and trains staff in these agencies around alcohol and drug issues, recognition, and motivation for referral.

Contact Time:

There is no minimum or maximum length of stay in the program. Clients get treatment as long as needed. The average length is 48 weeks.

Leader Type and Training Provided:

Staff training is provided in the content areas. All staff are trained in sexual abuse and trauma. Specialization in addiction is required.

Peer training is provided in conjunction with field placements from university and college programs. Training involves the basics of harm reduction, suicide intervention, and group facilitation and individual counselling.

Results:

For youth who have participated in the program, 50% achieve abstinence over time; 25% achieve substantial reduction in the use of alcohol and other drugs; and 25% report no change or get worse.

For youth who are in school and who have participated in the program, on average their marks go up 8%; their achievement of credits goes up 17%; and 85% complete the school year. For those youth identified by teachers as "at risk for school drop-out", 80% completed the school year.

Prevention Principles Most Reflected:

This program reflects a number of best practice principles. These principles include: addressing protective and risk factors; seeking comprehensiveness; ensuring sufficient program duration and intensity; family systems work; evaluating outcomes; accounting for the implications of adolescent development; recognizing youth perceptions of substance abuse; delivering credible messages; providing both knowledge and skills development; using group processes, and giving attention to training.

The strengths of the program include taking a comprehensive, systematic approach, and working closely with other agencies. More specifically, key strengths include engaging youth by focusing on the person rather than on the drug use; and taking a harm reduction approach during the early stages that includes stressing the importance of stopping the use of needles but also providing information on safe injection techniques, while striving toward abstinence as the safest goal. Other strong points include taking the time that it takes to deal with the issues that need to be addressed; making sure the kids know they can always come back into the program; and ensuring the program is respectful and safe. Finally, the program recognizes that injection drug users need at least one contact a day, and has put in place the partnerships to ensure that this takes place.

Year Program Established:

Rideauwood was established in 1976. The Youth Substance Abuse and Parent Programs were established in 1979, and the school component in 1986. The Young Adult Program was established in 1995. Working with the home for unwed mothers was established in 1999.

Program Sponsors:

Ontario Ministry of Health;
Community Fundraising (i.e. partnerships with schools);
Ontario Ministry of Community and Social Services.

Contact:

Mr. R. Paul Welsh
Rideauwood Addiction and Family Services
6 Hamilton Avenue North
Ottawa, ON K1Y 4R1
Tel: (613) 724-4881
Fax: (613) 724-4873
Email: rideauwood@iosphere.met

Downtown Eastside Youth Activities Society [DEYAS]

Target Population:

Selective; Street involved people of Vancouver's Downtown Eastside. The agency's priority is youth, but in addition it runs some programs that serve adults.

Setting:

Street, defined community (downtown, eastside Vancouver).

Program Description:

DEYAS provides 'windows of opportunity' to those who want to make a lifestyle change or to exit the street, and it promotes health and safety to those who are unwilling or unable to leave their circumstances. Interventions include crisis management, advocacy, service referrals, counselling and risk reduction initiatives.

The following DEYAS programs are targeted at youth:

Youth Street Project and Reconnect Program

The Youth Street Project and Reconnect Program delivers primary services to street involved youth of the Vancouver Downtown Eastside. Reconnect is a provincial program that operates in many communities throughout the province. The goal of the program is to prevent children and youth who have run away from their homes from becoming street involved, or to assist them in meeting their basic needs if they choose to remain on their own. All services are provided in coordination with the Ministry for Children and Families, other service agencies and other Reconnect agencies. Outreach provides street involved youth with "windows of opportunity" to make changes in their lives, whether they choose to exit the street, or to remain in their current situation. Staff provide direct counselling and referrals to services.

Youth Action Centre

The Youth Action Centre is a storefront drop-in centre that provides a safe environment where young people in Vancouver's Downtown Eastside can hang out, access services, interact with other service providers, and meet their daily dietary and personal needs. The Centre is open seven days a week with a minimum of two staff on site at all times. Among the services provided at the Centre are three hot meals daily, showers, laundry facilities, housing advocacy, cultural activities, recreational activities, a women's group, brotherhood and billiards, art programs, horticultural therapists, food bank, and a youth incentive program.

Phases Program

This program provides referrals, advocacy, and skills building to assist young people in finding employment and employment related programs, housing, and to ease the transition to mainstream society. The Phases Program is coordinated with the Youth Detox to provide an additional outreach worker and life skills as well as to better address drug- and alcohol-related issues.

Youth Detox

The Youth Detox is a community-based detox program that works in conjunction with other programs to provide youth with choices in detox and other alcohol and drug services. The program is dedicated to providing an holistic approach to alcohol and drug services for street-involved youth, addressing drug related issues and also other relevant issues such as housing, legal, medical, financial, etc. Information and education are provided on the continuum of alcohol and drug services from abstinence to moderation to damage control to harm reduction. This program is designed for youth who derive most of their economic, financial, social, or emotional needs from the streets of the Downtown Eastside of Vancouver. The program defines youth as persons who are aged 13 to 25, with priority placed on youth who are under 19 years of age.

Contact Time:

Ongoing as needs dictate.

Leader Type and Training Provided:

Outreach and some peer.

Prevention Principles Most Reflected:

DEYAS gives emphasis to forging a close relationship between the clients, the business community, local residents, leaders in Vancouver and the provincial government. One of the project's objectives is to ensure that all participating agencies are aware of their mandate and activities.

It is difficult to tell from their program description how much use they are making of peer interventions versus professional staff outreach. Some studies have shown the success rate on contacting this youth street population increases with the use of peers as the level of trust is much higher with "their own kind".

Associated Studies:

Steal and pawn dusk to dawn; by Alysia Davies for the Steering Committee of the Downtown Eastside Neighbourhood Safety Office.

Program Sponsors:

Medical guidance and supervision:
Vancouver Native Health Society.

Funding:
Vancouver/Richmond Health Board and the BC Centre for Excellence in HIV/AIDS.

Contact:

John Turvey, Project Director
or
Judy McQuire, Needle Exchange, Community Strategies
DEYAS
Downtown Eastside Youth Activities Society
223 Main Street, Vancouver BC V6A 2S7

Exit Community Outreach

Target Population:

Youth ages 12 to 24.

Setting:

Street.

Youth Involvement in Program Development or Delivery:

Youth input is sought in the delivery of service.

Youth Needs Addressed:

Health, Safety, Crisis Counselling, Referrals.

Interventions Used:

Formal instruction/training; Informal learning; Resource centre; Drop-in centre; Counselling; Referrals.

Intended Outcomes:

Reduced use; Adoption of healthy recreational alternatives; Improved personal and social skills; More accurate understanding of prevalence of drug use; Improved awareness of services/help; Increased access to services; Increased community awareness.

Program Description:

Exit is a downtown store-front outreach service that assists young people who have run away, or who are at risk of self-harm, or are involved with prostitution. The young people may also be in conflict with community, family or legal systems. Exit is one of a comprehensive range of programs offered by Wood's Homes.

Contact Time:

Very flexible. Run three set groups per week.

Agencies Involved in Program Delivery:

Safe Works (needle exchange); Street Teams (youth prostitution); AIDS Calgary; Calgary Birth Control Association.

Program Costs:

Program is funded through Rocky View Child and Family Services, Alberta Mental Health, City of Calgary, United Way and donations.

Prevention Principles Most Reflected:

Exit is committed to supporting self-sufficiency by coordinating resources to assist and support young people who exist on Calgary streets; the aim of Exit is to reach youth who have been abandoned or are at risk on the street; through counselling and service referral, Exit promotes the health of young people while they exist on the streets and provides assistance when they choose to leave the streets.

Year Program Established:

1989.

Contact:

Mr. Colin Hill
Wood's Homes
805 37th Street North West
Calgary, AB T2N 4N8
Tel: (403) 282-9953
Fax: (403) 264-6335

First Contact, A Brief Treatment for Young Drug Users

Target Population:

Indicated; youth ages 14-25 who are using substances.

Setting:

Community.

Youth Involvement in Program Development or Delivery:

A client advisory committee had input in all aspects.

Youth Needs Addressed:

Readiness to change, pre-treatment or stand-alone, early intervention - decision to change, triggers, consequences and alternatives, goals, stages of change.

Interventions Used:

The First Contact treatment manual presents procedures, tools and exercises to be used with youth individually or in group format. A motivational counseling approach is taken to help youth examine their drug use, look at the pros and cons of changing, identify situations that put them at risk, and develop strategies to deal with these situations. First Contact can be used as a stand-alone intervention or as a first step for youth who need more intensive or ongoing treatment.

Intended Outcomes:

Reduced use; Adoption of healthy recreational alternatives; Improved personal and social skills; More accurate understanding of prevalence of drug use; Improved relationship with parents; Improved awareness of services/help; Increased access to services.

Program Description:

Program is being used with francophone adolescents between 12 and 18 years of age at Maison Fraternité. The objectives of the program are:

- to help to understand the problems related to the use of alcohol and drugs;
- to help find alternatives to the use of alcohol and drugs;
- to bring the youth to take control of their lives;
- to offer support to maintain a better quality of life without alcohol and drugs;
- to help members of the family find solutions to resolve conflict situations related to the use of alcohol and drugs by their youth.

Services offered

To youth: evaluation, treatment plan, individual therapy and group therapy;

To the family: parent group, parental counselling, family therapy;

Day care: For youth (14 to 18) who accept to work toward an objective of abstinence; three-month school and therapy program.

Results

An evaluation of First Contact was conducted at the Centre for Addiction and Mental Health. At six-month post treatment, clients reported:

Significant reductions in drug use;

Significant reductions in negative consequences related to drug use.

Contact Time:

Assessment and feedback; four sessions / 2 hrs each. Clients can be referred on for more intense treatment or continuing care.

Agencies Involved in Program Delivery:

Ontario Youth Managers Coordinating Group (Youth Addiction Agencies in Ontario) were involved in program development and many are currently using the materials. Also relevant to social services, schools, young offenders programs and mental health services. The Centre for Addiction and Mental Health is offering the program to youth in clinical service and community settings.

Program Costs:

The program requires two part-time trained clinicians for the group modality or one clinician for individual counselling. The manuals are available in both English and French from CAMH Sales and Marketing for $24.95 in Ontario and $29.95 outside Ontario and provides training and implementation consultation to service providers.

Prevention Principles Most Reflected:

Understand and involve young people; realistic goals; accurate research-based information; sustainability.

Year Program Established:

1997.

Contact:

Local implementation:

Mr. Rolland Choquett
Maison Fraternité
Service de thérapie en toxicomanie pour adolescents(es) et leur famille
260, rue Dalhousie, 4e étage
Ottawa, ON
K1N 7E4
Tel: (613) 562-1415
Fax: (613) 562-1418

Program materials:

Elsbeth Tupker
Senior Program Consultant
Centre for Addiction and Mental Health
33 Russell Street, Toronto, ON, M5S 2S1
Tel: (416) 535-8501, ext. 4544
Fax: (416) 595-5019
Email: Elsbeth_Tupker@camh.net
Sales and Marketing: 1-800-661-1111

HIV Education Program

Target Population:

High-risk youth and also staff of the Youth Services Bureau and community agencies dealing with them.

Setting:

Community.

Youth Involvement in Program Development or Delivery:

A key principle of the program is to engage youth in development of youth-focused programming pertinent to their needs.

Program Description:

Theoretic Basis

Harm reduction/Healthy lifestyle.

General Description

The main approach of the program is to provide lifestyle choices and support to youth through harm reduction and healthy lifestyle education. The HIV Education Program provides HIV/AIDS education to high-risk youth in Ottawa-Carleton. Principles include developing partnerships with other HIV/AIDS services in Ottawa and at the national level, as well as participation in local community events. The needle exchange program is not mobile, but is maintained by HIV Education Program staff through the drop-in centre.

Components

Presentations: the program provides youth-friendly presentations to meet youth where they are at and where they gather (alternative schools, correctional facilities, drop-in centres). Presentations include IDU information, where to get testing for STD's, Hepatitis, HIV.

Drop-in centre: staff interact with youth in the drop-in centre, and use the opportunity to provide one-on-one information sharing on safe injection techniques, safe sex, etc. The drop-in centre has an anonymous question board where questions can be left by youth and a typed response is provided on the board.

Community participation: staff participate in community events and multi-agency meetings and provide information on HIV/AIDS issues.

Education: education programs are youth driven, and engage youth through a variety of strategies. An example of an educational strategy is Fact or Myth. In this strategy, through an information booth at an event, youth are given a card with a fact/myth written on it. This leads to discussion with other youth at the event about the topic. Peer education is another program strategy and is carried out primarily through the involvement of youth in the Downtown Youth Advisory Committee. Through this committee, youth learn facilitation and leadership skills.

Needle Exchange: the Needle Exchange program is not mobile, but is provided through the drop-in centre. Safe injection and referral information is provided as part of the program.

Messages

The program is youth focused, and is based on the choices and needs of youth. The program starts where youth are at, and moves toward how they can live independently. The program supports client choices.

Knowledge and Skills Developed

Through the Downtown Youth Advisory Committee youth learn leadership, peer support, how to take ownership for their own lives, modeling for other youth, public speaking, and community organization.

Youth using the needle exchange program or the drop-in centre develop knowledge about HIV/AIDS, safe injection techniques, sexual health, as well as learn there is a safe place to go.

Means of Reaching Individuals Involved in Injection Drug Use

The program reaches youth by being visible in the community and by being 'where youth are'. The program is promoted via youth talking to other youth and through outreach workers. Other means of promotion include advertising through the Youth Services Bureau. A manual about the program is under development.

Contact Time:

Ongoing.

Leader Type and Training Provided:

Train the trainer. Peer education. Staff training.

Results:

A formal evaluation is not available, however the program is regularly re-focused based on formal and informal feedback from youth.

Prevention Principles Most Reflected:

This program reflects a number of best practice principles. These principles include recognizing youth perceptions of substance use; involving youth in program design and implementation; developing credible messages that are delivered by credible communicators; combining knowledge and skills development; using interactive groups process; and giving attention to teacher and leader qualities and training.

More specifically, the strengths of the program include engaging youth in the development of youth-focused programming pertinent to their needs, and providing youth-friendly presentations in locations where youth gather.

Year Program Established:

1992.

Contact:

Ms. Stacy Lauridsen
Youth Services Bureau
147 Besserer
Ottawa, ON K1N 6A7
Tel: (613)241-7788
Email: aids@ysb.on.ca

Intervention par les pairs auprès des jeunes de la rue du centre-ville de Montréal

Clientèle cible :

Sélective: Jeunes en difficulté du centre-ville (12-25 ans) avec accent sur les jeunes utilisateurs de drogues par injection et les jeunes garçons prostitués.

Contexte :

Sur la rue, centres communautaires, établissement (CACTUS, Séro-O, Dollard Cormier, Bon Dieu dans la rue).

Description de l'intervention :

Base théorique

Le modèle utilisé est celui de Pucham, modèle développé pour les interventions par les pairs.

Il s'agit de huit jeunes de la rue qui ont « raccroché » et qui sont formés pour intervenir auprès de leurs pairs. Une approche a été développée pour les pairs avec les pairs et comprend :

- l'écoute active,
- une relation d'aide,
- de l'information sur les ressources existantes,
- des références.

Heures de contact, y compris les séances de motivation :

Les heures d'intervention varient selon le milieu, mais les interventions sont généralement pratiquées entre 12 h et 21 h.

Type d'encadrement et formation offerte :

À venir.

Équipe de recherche :

Des travaux de recherches sur ces services ont été effectués par Mme Céline Mercier professeure associée à l'Université de Montréal et chercheure pour l'Hôpital Douglas (mercel@douglas.mcgill.ca).

Résultats escomptés :

Les meilleurs résultats sont obtenus par :

- une approche globale plutôt que trop spécifique à une problématique;
- des critères de sélection plus serrés pour le choix des pairs aidant;
- une formation plus articulée pour les pairs aidant.

Bailleurs de fonds :

Direction de la santé publique de la Régie régionale de Montréal: 70 000 $ - 75 000 $ budget de base.

Programme d'action communautaire sur le SIDA (PACS) : 20 000 $ - 25 000 $ budget complémentaire.

Année de création du programme :

Le programme est en vigueur depuis 1993.

Études, enquêtes, articles connexes :

À venir.

Programmes de formation et de consultation offerts :

La formation dispensée aux pairs aidants provient des intervenants en Centre Local des Services Communautaires (CLSC).

Personne-ressource :

Madame Diane Demers
Chef de program en CLSC
CLSC Centre Ville
1250, rue de Sanguinet, 3e étage
Montréal (Québec)
H2X 3E7
Tél: (514) 844-0630

McDougall House

Target Population:

Young women with substance use and other issues; the program includes Aboriginal clients.

Setting:

Community.

Program Description:

Theoretic Basis

Transtheoretical model of change; Reality therapy; Rational emotive therapy.

General Description

The program is abstinence-based, however information on safe injection is provided, should the clients find themselves using again. This program is based in a long-term residential facility and is female gender specific, serving youth and adults. The focus of the program is to provide a stable environment for clients to make changes in their lives. A major program goal is to have every client fully employed, or in school, upon discharge.

Components

Case conferences: Case conferences are held with clients immediately upon admission to set short- and long- term goals.

Treatment: The program focuses on the issues that have brought the clients to McDougall House, and includes workshops on self-esteem building and basic life skills. Group therapy and individual counselling are provided.

There is also a physical exercise program, and a meditation program. Good nutrition is taught through regular, balanced meals. The program also deals with issues of the street, and works with the issues of injection drug use such as lifestyle, problem solving, and relapse prevention. Peer support is also a part of the program.

Referral: Referrals are made to employment programs that are specifically targeted to people who have been on the street. Importance is placed on clients having a network of support services in place before discharge. For instance, clients are encouraged to have regular outpatient counselling sessions underway before leaving McDougall House.

Messages

McDougall House is a safe, supportive environment for clients to deal with the issues that have brought them to this place in their lives. In order to successfully address issues, clients must be abstinent from drugs.

Knowledge and Skills Developed

Clients learn basic living skills, job search skills, problem solving, and relapse prevention.

Means of Reaching Individuals Involved in Injection Drug Use

Clients who are living in the house go out and encourage people they know on the street to come into the program. Other means include referral from other treatment centers, and outreach to the media to do an article or television story.

Contact Time:

Average time is 6 to 9 months. Minimum is 3 months, but 12 months is an option.

Leader Type and Training Provided:

HIV safety training and awareness for staff. Peer support training. Staff training through the Alberta Alcohol and Drug Abuse Commission.

Results:

Sixty percent of clients are employed or going to school when discharged. Clients are 'doing' their plan when they leave the centre.

Prevention Principles Most Reflected:

This program reflects a number of best practice principles. These principles include program comprehensiveness; sufficient program duration; credible messages; knowledge and skills development; interactive group process; and attention to training.

The broad strengths of the program include focusing on the issues that have brought the clients to this place in their lives, and working toward every client being fully employed, or in school, upon discharge. More specific program strengths include referring to employment programs that are especially targeted to people who have been on the street, and ensuring clients have a network of support services in place before discharge.

Year Program Established:

1969.

Program Sponsors:

Alberta Alcohol and Drug Abuse Commission.

Contact:

Ms. Sandy Livingstone
McDougall House Association
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Fax: (780) 429-3459
Email: mha@powersurfr.com

Keep Six Needle Exchange Program

Target population:

Injection drug users.

Setting:

Street.

Theoretic Basis:

Harm reduction with some behaviour change/modification.

Approach Used:

Approach includes needle distribution, rather than just needle exchange.

Contact Time:

Ongoing.

Program Description:

Youth injection drug users are a significant segment of the client group served by this program. The program started with outreach workers who had contacts with recently released inmates. In the beginning, workers delivered syringes to client homes via bicycles. The program now operates out of a storefront center in the downtown core (close to youth shelters, detoxification centre, bars).

The program provides needle exchange services to youth, as well as to adult, injection drug users. Services are provided from a downtown store-front; a mobile van; and via visits to client homes. Safe injection and primary health care information are provided, and clients are referred to appropriate community agencies.

A number of other programs have stemmed from the Needle Exchange Program. All of these programs have youth as clients. These programs include: the Methadone Clinic, the Aboriginal Program (outreach to correctional facilities), Creating A Better Life Program (targeted to women 18 to 55); Child Focus Program (care for children of clients); and a Youth Clinic.

Components

Needle Exchange and Distribution: needle exchange and distribution is provided from a mobile van, as well as via visits to client homes. The program will provide syringes without returns, however returns are encouraged through ownership of the program in the community. Peer helpers are used in the needle exchange program.

Information: information is provided on safe injection methods and primary health care. A key strategy is to recruit staff with the relevant life experience and skills to be able to go into client homes and advise on safe injection techniques. (The program finds that young people are more receptive than older clients to harm reduction information.) A newsletter is produced that includes articles by users.

Referral: clients are referred to community services such as the food-bank or to health care services.

Outreach: the program uses peer helpers (users and ex-users) to make contacts with the client group. Especially useful are peer helpers with contacts in the recently released prison population.

Health Care: periodically, a nurse travels out in the van and tests for HCV, HIV, or vaccinates for HCB. Staff arrange health care coverage by registering clients with the Ontario Health Insurance Program.

Messages

Avoid infections such as HCV and HIV by using safe injection procedures.

Behave appropriately when visiting the store-front centre.

Knowledge and Skills Developed

Safe injection methods; knowledge of health care services and other services in the community.

Means of Reaching Individuals Involved in Injection Drug Use

Methods to reach clients include building trust and ownership of the program in the community. Other strategies include recruiting outreach workers and peer helpers with contacts in the community. (i.e. workers connected to people newly released from jail).

Leader Type and Training Provided:

Provide training to staff, volunteers, and peer helpers. Includes basic harm reduction information, safe injection practices, community referral information.

Intended Outcomes:

The program finds a return rate of 80% of used needles. Other achievements are: clients have health cards; have been vaccinated for HCB; and have been tested for HIV and HCV. A key result is that clients continue to participate in the program. A University of Toronto study found a low incidence of seroconversion (production of antibodies in response to HIV and HCV) in the Kingston area. Developed a manual on setting up a needle exchange. Consulted with other agencies on setting up a needle exchange.

Prevention Principles Most Reflected:

This program reflects a number of best practice principles. These principles include: ensuring sufficient program duration; addressing program sustainability; recognizing youth perceptions of substance use; developing credible messages; combining knowledge and skills development; and giving attention to training.

Key program strengths include building trust and ownership of the program in the community; hiring outreach workers with relevant life experience; recruiting peer helpers with contacts in the community; and providing training to staff, volunteers, and peer helpers. A particular strength lies in the flexibility of the services: needles are distributed, not just exchanged, and workers go into client homes to advise on safe injection practices.

Year Program Established:

1989.

Program Sponsors:

Ontario Ministry of Health
Health Canada
Sunnyside Children's Foundation

Contact:

Ms. Tina Knorr
Keep Six Needle Exchange Program
Kingston Frontenac Lenox Addington Health Unit
6 Montreal Street
Kingston,ON K7L3G6
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Point de repère (1990)

Population cible :

Sélective : hommes et femmes/prostitué(e)s, jeunes de la rue, prisonniers.

Contexte :

Piqueries, centre de détention, endroit de vie des personnes prostitué(e)s (rue, appartement, piqueries, restaurants, etc.) et la rue.

Description du programme :

Point de repère offre des services :

- d'accueil,
- d'information et de sensibilisation,
- d'education,
- de dépistage anonyme du VIH,
- d'évaluation et de référence,
- de distribution et d'échange de seringues,
- de distribution de condoms,
- de support psychosocial.

Aux personnes toxicomanes qui utilisent des drogues par injection, les prostitué(e)s hommes et femmes, les jeunes de la rue et les personnes incarcérées en situation d'échange de seringues et de pratiques sexuelles à risque.

Durée/Moment de l'intervention :

Les interventions sont principalement faites sur la rue entre 21 h et 4 h. Toutefois le jour permet d'assurer un suivi auprès des personnes.

Base théorique :

- béhavioriste,
- gestalt,
- analyse transactionnelle,
- Alcoolique Anonyme.

Cinquante pourcent des intervenants sont des ex-toxicomanes et ex-prostitué(e)s qui ont une formation en travail social.

Encadrement et formation :

Un encadrement et une supervision clinique sont fournis aux intervenants par le biais d'une rencontre aux trois jours.

Équipe de recherche :

Les services offerts par Point de repère sont suivis par un projet de recherche depuis ses débuts. Les chercheurs proviennent de 1'Université Laval et de la Direction de la santé publique de la Régie régionale de la santé et des services sociaux du Québec.

Résultats escomptés :

Selon le responsable de Point de repère, les meilleurs résultats de services sont obtenus par :

- l'échange de seringues (70 à 80 % de retour);
- la stabilité de l'équipe d'intervenants professionnels.

Bailleurs de fonds :

- Ministère de la santé et des services sociaux du Québec : 270 000 $ (budget de base);
- Régie régionale de la santé et des services sociaux du Québec : 40 000 $ (volet carcéral); 40 000 $ (milieu de vie);
- Santé Canada: 40 000 $ (femmes prostituées); 50 000 $ (hépatite C).

Année de création du programme :

Le programme est en vigueur depuis 1991.

Études reliées, enquêtes, articles :

Point de repère a fait l'objet de nombreux projets de recherches. Des vidéos ont également été produites.

Disponibilité des programmes de formation et de consultation :

Point de repère n'offre pas de formation ou de consultation.

Personne-ressource :

M. Gilles Marquis (Directeur)
335, de St-Vallier est
Québec (Québec) GIK 3P7
TB1.: (418) 648-8042
TBlec: (418) 648-0972

Streetworks

Target population:

Injection drug users; sex trade workers; intimate partners; community agencies and businesses (10% of clientele are youth).

Setting:

Street; Community.

Program Description:

Theoretic Basis

Harm reduction; Health promotion; Transtheoretical Model of Change.

General Desciption

The Streetworks program operates out of five centers in the Boyle Street area of Edmonton. The program also operates out of a van and via outreach workers with backpacks. Streetworks takes a comprehensive program approach. The goals of the program are to prevent the transmission of HIV and other bloodborne pathogens; and to provide and enhance the skills, knowledge, and support for people to live safer and healthier lives. A full-time staff member works with youth.

Components

Pharmacy Program: involves pharmacies that have indicated a willingness to accept dirty needles and to sell back clean needles. They also provide harm reduction information to the target group.

Ride Along Program: is intended to provide an opportunity for other agencies to go out with Streetworks workers and provide information about their services to clients (eg. Student Legal Services).

Health Education: is provided to the target group by nurses and outreach workers. Harm reduction information is provided such as safe injection methods and safe sex. The outreach workers also provide information on how to live safely and protect oneself on the street.

Newsletter: is intended to provide information to the target group. It includes articles about the Streetworks program, as well as contributions from clients.

Prison Outreach: workers regularly visit correctional facilities and provide harm reduction and health information. They emphasize the information is intended for use when the inmates are released.

Nursing Services: provide basic health care such as immunization and dressing changes, as well as appropriate referrals.

Advocacy Services: the intention is to bridge the gap between the mainstream and the street. Workers consult with mainstream services such as social service agencies and medical clinics on ways to respond to street people with respect and understanding. Workers also assist street people by going with them to agencies and clinics, or by providing information on what to expect when visiting a medical clinic, STD clinic, social service agency, etc.

Needle Exchange Tool Provision Program: the program supplies all the tools that are needed for safe injection.

Natural Helpers Program: the program recognizes that there are people who are always helping other people in the community. This program provides additional support and resources to these helpers. The program has developed posters and two handbooks: Vein Care Handbook; and Street First Aid: Cause You Just Never Know.

Referrals Program: the intention of the program is to make referrals that are appropriate to the needs, and level of sophistication of the client. Staff always ensure they are familiar with an agency or service before referring clients.

Research and Evaluation: program evaluation is ongoing. A researcher is currently interviewing clients to identify where specific research needs to be done.

Support Group: is targeted at individuals who are currently injecting but are at the point where they are contemplating change. The Support Group provides a network, information, and resources to assist individuals on moving to a place in their lives where they can stop using, and to deal with being sober.

Messages

Key messages of Streetworks are harm reduction and partnering with clients. Staff ask 'How can we provide clients with what they need to be safer and healthier'. They support 'care-giving, not care taking.' Streetworks is a strength-building program, and a key message is to build on the strengths of the clients (i.e. tell the clients it is great they used an alcohol wipe each time).

Knowledge and Skills Developed

Knowledge of safer injection skills and safer sex techniques. Information on how to protect themselves on the street. Sense of control and influence over their lives. Self-confidence and a vision and hope for the future.

Means of Reaching Individuals Involved in Injection Drug Use

Streetworks reaches clients mainly through reputation. For example, to reach street youth, Streetworks builds trust with current clients (both adult and youth), and finds that when clients trust the program, they will promote the program to youth. As well, Streetworks promotes the program by building partnerships with specific youth agencies.

Contact Time:

Ongoing.

Leader Type and Training Provided:

One-on-one training as opportunities arise.

Results:

Evaluations are ongoing. A recent published study found that the Streetworks program has a cost-effectiveness of $9,500 per HIV infection delayed for one year. Reference: Cost effectiveness of Streetworks' needle exchange program of Edmonton by Jasobs P; Calder P; Taylor M; Houston S; Saunders LD; Albert T. Canadian Journal of Public Health, 90(3): 68-71 1999 May-June.

Prevention Principles Most Reflected:

This program reflects a number of best practice principles. These principles include: addressing protective and risk factors; taking a comprehensive approach; ensuring sufficient program duration; evaluating the program; addressing program sustainability; recognizing youth perceptions of substance use; developing credible messages; combining knowledge and skills development; and attending to training.

Specifically, program strong points include taking a strength-building approach to harm reduction; bridging the gap between the mainstream and the street; providing support and resources to community helpers; and making referrals that are appropriate to the needs and the sophistication-level of the client.

Year Program Established:

1990.

Program Sponsors:

Capital Health Authority; Alberta Health; Alberta Lotteries — Community Lottery Board grant.

Contact:

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Email: tjasperson@boylestcoop.org

Section 6

Appendix

This section contains several additional resources:

- Prevention principles checklist: a summary of questions drawn from Section 3. The checklist is intended to be used as a tool for briefly assessing a program;
- Study quality and outcomes rating form: the form that was used by raters of the published articles found in Section 4;
- Authoritative reviews of youth substance use problem prevention effectiveness: reviews referred to in the development of the compendium;
- Articles associated with published programs: articles by which published programs were rated;
- Index of programs: a listing of programs described in the compendium and where to find them.

Prevention Principles Checklist

1. Address protective and risk factors and promote resiliency

- ☐ What risk factors does our program address (individual, family, school and/or community)?
- ☐ Do we give more emphasis to promoting protective factors (or resiliency) than reducing risk factors?
- ☐ Have we worked with other agencies to address shared protective or risk factors?
- ☐ Have we considered the impact of the broad determinants of health (e.g., income and educational levels, social supports, early childhood experiences) in our community?

2. Seek Comprehensiveness

- ☐ Do we involve other sectors (e.g., parents/families, schools, agencies) in our program?
- ☐ Are we working with all relevant agencies and stakeholders, including reaching out to new groups (for example, those who interact with high-risk youth?)
- ☐ Does our organization support its staff in working with other agencies? Are we advocating for a comprehensive approach and comprehensive policies from local school boards, health boards, addiction agencies and others?
- ☐ Do government regulations and their enforcement provide adequate support for our aims?
- ☐ Is preventative attention being given to all ages of children and youth in the community?
- ☐ Is there a good mix of programming for youth at various levels of risk in our community?

3. Ensure Program Duration and Intensity

- ☐ Have we clearly identified our target group?
- ☐ Is the length and intensity of the program appropriate for our target group and sufficient for our intended outcomes?
- ☐ When selecting at-risk youth for programming, do we have a reasonable basis for selection (e.g., poor academic performance, alcohol dependent parent)?
- ☐ When selecting at-risk youth, how do we avoid labelling and stigmatization?
- ☐ When targeting an Indicated population, do we have effective ways to identify and recruit participants (e.g., conduct problem at school as identified by guidance counsellor)?
- ☐ When working with high-risk youth, in what way do we seek to address their multiple needs?

4. Base Program on Accurate Information

- ☐ Have we assessed local needs, issues and concerns with respect to substance use?
- ☐ Are there specific substances or substance use patterns that we need to address through our program?
- ☐ How much do we know about the extent of occasional, regular and heavy use (and age, gender differences) among our participants or group we wish to engage?
- ☐ Do we have more than one source of information on usage patterns?

5. Set Clear and Realistic Goals

- ☐ Do we have an overall plan or strategy for achieving our program goals?
- ☐ Are our program goals appropriate in light of age and use patterns of youth we wish to engage?
- ☐ Are our goals and objectives linked logically and are they measurable and time-limited?
- ☐ Do our program activities link logically to our objectives?

6. Monitor and Evaluate the Program

- ☐ Do we devote a set percentage of our budget for evaluation?
- ☐ In what way(s) do we evaluate our program?
- ☐ What can we say about our program's impact? Does it achieve what is expected?
- ☐ Have we monitored the process (activities, number of participants, timelines, community support, etc.) throughout?
- ☐ Have we sought participant and stakeholder feedback and revised our program based on that feedback?
- ☐ What can we say about our program's costs (direct and indirect) to our agency, our participants and partners?

7. Address Sustainability from the Beginning

- ☐ If sponsored, how fully have we integrated our program into our sponsoring organization in terms of its policies, staffing, core budget, training, and other forms of support?
- ☐ To what extent do we rely on short-term funding?
- ☐ Do we have strategies planned for longer-term funding such as fund-raising, foundation grants, and registration fees from participants?
- ☐ Do we have the appropriate stakeholders and partners involved and do they have a long-term commitment to the program?
- ☐ How much do we contribute to sensitizing the public to substance use issues in our community?

8. Account for the Implications of Adolescent Psychosocial Development

- ☐ Does our programming approach match the stage of development of participants?
- ☐ Does our program reflect an understanding of the vulnerability associated with the early adolescents phase of development (e.g., impulsive, reckless behaviour)?
- ☐ Does our program take general adolescent psychosocial needs into account, such as: the need to be independent, consider values distinct from parents and authorities, take risks, join a peer group, form lasting relationships with others?
- ☐ If working with higher risk youth, do we support their development of a healthy self-identity with achievable tasks and realistic goals?

9. Recognize Youth Perceptions of Substance Use

- ☐ Does our program acknowledge both the perceived benefits of using substances and the perceived benefits of not using in a balanced, unbiased manner?
- ☐ Do we provide tools for youth to weigh the costs and benefits themselves and make appropriate decisions?
- ☐ Do we address perceptions that some youth hold about drugs?
- ☐ Do we understand why our participants or youth of interest might use substances?
- ☐ Does our program give more attention to immediate social consequences (vs. long term) health risks and consequences?

10. Involve Youth in Program Design and Implementation

- ☐ Do we give adequate effort to maintaining the trust and respect of our participants?
- ☐ To what extent are young people involved in designing, implementing and evaluating the program? Is it more than "tokenism"?
- ☐ Do we provide our youth with appropriate support, such as payment or some other form of compensation for their involvement, transportation, accessible hours, and back-up support?
- ☐ Do we ensure that youth members are representative of the population we want to serve?
- ☐ Do we plan for turnover of our youth and have successors in place?

11. Develop Credible Messages

- ☐ Have we involved youth in the development of messages?
- ☐ Do our messages match our overall goals for the program (e.g., harm reduction messages such as avoiding drinking and driving, chugging, unplanned sex)?
- ☐ Do we avoid scare tactics and misleading information?
- ☐ Do we avoid simplistic messages such as "just say no" or "play sports"?

- ☐ Do we take social norms and issues relating to specific subcultures into account?
- ☐ What are the unspoken implied messages (e.g., participants are worthy of respect)?
- ☐ To what extent have we connected messages to issues or attributes that are important to youth (e.g., relationships, getting ahead, managing stress and physical attractiveness)?

12. Combine Knowledge, and Skills Development

- ☐ Does our program present practical information about alcohol and other drugs in a factual and balanced way?
- ☐ Does our program teach general life skills (e.g., coping skills, conflict resolution, problem-solving, decision-making, communications skills)?
- ☐ Does our program allow youth to role-play or rehearse strategies to avoid or manage higher risk situations?
- ☐ Does our program address influences of drug use, including societal and media influences?
- ☐ Does our program address participant self-confidence, where to find help, overcoming barriers to getting help, and providing help to others?
- ☐ Does our program address other concerns of youth (e.g., failing grades, poor peer relationships), recognizing the link between those concerns and drug use?

13. Use Interactive Group Process

- ☐ Does our program use activity-based learning strategies rather than didactic methods?
- ☐ Does our program help participants to reflect on what they are learning (journal writing, small group discussions, encouraging conversation with close friends) and to set goals for changes in their lives?
- ☐ Do we use peers in program delivery in a meaningful way?

14. Give Attention to Teacher or Leader Qualities and Training

- ☐ Do the participants consider our leaders credible?
- ☐ Are our program leaders/teachers comfortable with a facilitative role within an interactive approach?
- ☐ Do our program leaders convey empathy and encourage youth involvement?
- ☐ Do we provide training and support for leaders/teachers?
- ☐ Are participants given a chance to evaluate program leaders?

Study Quality and Outcomes Rating Form

Program: _____

Title of Article: _____

Author: _____

Publication Date: _____

	Item	Criteria	Score
		Study Quality	
1	Sampling technique	If randomized=2pts; quasi-exp=0	/2
2	Comparison group	Equivalence at baseline (differences controlled)=1pt	/1
3	Attrition rate	Non-differential attrition (differences controlled)=1pt	/1
4	Accounting for non-participants	If accounted for and similar to participants=1pt	/1
5	Data collection instruments	Reliable and valid=1pt	/1
		Outcomes	
6	Findings	Positive effect on behaviour (inc. delayed onset)=2pt; Positive effect on beliefs=1pt; Positive effect on intermediary factors (e.g. school bonding, antisocial behaviour, school achievement); = 1pt. Intermediary factors measured_____	/4
7	Duration of effect measured	Following completion of the intervention. 1 year or >=1pt; 2 year or >=2pt	/2
8	Extent of compliance or fidelity to designed intervention	If compliant=1pt	/1
9	Extent of replication and outcomes	Using a program having shown + effect=1; in doing so, if showing behavioural results=1pt	/2
			Total /15

Comment:

_____

_____

_____

Note:

- Unless obvious discrepancy, will take authors word on measures taken
- If author does not address a criteria, score will be 0
- Full points only - all or nothing
- In findings section, score for each measure showing effect and add together; eg change in behaviour (2) + beliefs (1)=3

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Universal

School

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Botvin, G.J., Baker, E., Filazzola, A.D. and Botvin, E.M., A Cognitive-Behavioral Approach to Substance Abuse Prevention: A One Year Follow-up, Addictive Behaviors, Vol.15, 47-63. 1990.

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Index of Published Programs

Universal

School

All Stars - Adolescent Alcohol Prevention Trial 54
Alcohol Misuse Prevention Study 58
Illawara Program 61
Life Skills Training Program 65
Project ALERT 70
STARS 75

Family

Strengthening Families Program 79

Community

Project SixTeen 82
Saving Lives Program 85

Comprehensive

Midwestern Prevention Project (MPP) 88
Project Northland 92

Selective

School

Lifestyles '94 96
Opening Doors 98
Personal Growth Class 101
Project Toward No Drug Abuse 104
Seattle Social Development Project Intervention 108
Skills Training for College Students 112
Social Competence Promotion Program for Young Adolescents 115

Family

Adolescent Transitions Program 119
Creating Lasting Family Connections 122
Families and Schools Together 130

Community

Motivational Interviewing 135
Community Partnership Program 138
The Heroic Journey 140

Indicated

Family

Focus on Families 143

Community

AIDS Education for Male Adolescents in Jail 150
AIDS Evaluation of Street Outreach Project 152
Clean Needles Now 155
Intervention for Pregnant Injection Drug Users 157
Logan Square Prevention Project 159
Prevent Initiation of Drug Users into Injecting 163
UFO (U-Find-Out) Study 165
Substituting Naltrexone for Heroin 169

Index of Canadian Programs

Universal

School

Making Decisions: Grade 6 and Grade 7 175
Peer Support Program 177
Student Alcohol and Drug Use Policy and School Curriculum Resources 180
Teens Against Drinking and Driving (TADD) 184
Tuning In To Health 186
Your Life: Your Choice! 188

Family

Developing Capable People (DCP) 191

Community

C3 (Community Cooperation for Change): A Workable Solution 193
Communities in Action for Children and Youth 195
Drug Education and Awareness for Life (DEAL) 198
Media Arts Program 201
Opti-Jeunesse : Une force contre la toxicomanie 204
Town Youth Participation Strategies (TYPS) 206
Youth Web site Project 208

Comprehensive

Alcohol, Cannabis and Tobacco Health Promotion for Youth (ACTION) 210
Dallas Society Prevention Services 213

Selective

School

Aboriginal Shield 218
Opening Doors 220
Student Assistance for Everyone (S.A.F.E.) 222

Family

Families and Schools Together (F&ST) 224
Nobody's Perfect 226
Ready or Not 228

Community

Alternatives for Youth 230
Harm Reduction for Rural Youth 232
Healthy Choices for our Children 234
Let 'Em Go: The Street Involved Youth Harm Reduction Experience 237
Project Y.O.U. 239
Saskatoon Downtown Youth Centre/EGADZ 243
Teen Touch Inc. Helpline 246

Indicated

Family

Youth Substance Abuse and Parent Programs 248

Community

Downtown Eastside Youth Activities Society 252
Exit Community Outreach 255
First Contact, A Brief Treatment for Young Drug Users 257
HIV Education Program 260
Intervention par les pairs auprès des jeunes de la rue du centre-ville de Montréal 263
McDougall House 265
Keep Six Needle Exchange Program 267
Point de repère 270
Streetworks 272